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THE SEXUAL ABUSE INFORMATION RECORD (SAIR): ITS RATIONALE AND INCEPTION

BY
ROSEMARY MOSKAL ©

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILLMENT FOR THE DEGREE OF

DOCTOR IN PHILOSOPHY
IN
COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

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Rosemary Moskal

Rosemary Moskal
1164 Greenwood Avenue
Victoria, B.C.
V9A 5M1
(604)-380-2005

Date: December 15, 1994

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled THE SEXUAL ABUSE INFORMATION RECORD (SAIR): ITS RATIONALE AND INCEPTION submitted by ROSEMARY MOSKAL in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY in EDUCATIONAL PSYCHOLOGY (COUNSELLING).

H Zingle

Dr. H.W. Zingle (Dean and Supervisor)

Richard Sobsey

Dr. R. Sobsey (Chair)

Judy Cameron

Dr. J. Cameron

Barbara Paulson

Dr. B. Paulson

Stephen A. Kent

Dr. S.A. Kent

Dr. F. Ricks (University of Victoria)

Date: December 15, 1994

DEDICATION

This thesis is dedicated to two groups of people. First, to all those primary victims and their families who are in the process of healing from the trauma of sexual abuse and the other abuses so often perpetrated upon them concurrently. Although it is true that the impact of sexual abuse varies from individual to individual and the experience is perceived on a continuum of trauma, nonetheless, it is still traumatic for the vast majority who experience it. All those whose files were used for this research fell on this continuum.

This thesis is also dedicated to the Board Members and the Staff at the Victoria Child Sexual Abuse Society in British Columbia, who gave their permission, their skills, and their time for the data collection of this study. Like many other professionals, they continue to provide the practical realities of compassion and guidance for sexual abuse victims and their families.

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ABSTRACT

This thesis develops the Sexual Abuse Information Record (SAIR). For at least four reasons, professionals working with sexual abuse victims in agencies, institutions, or in private practice can adapt it for use. Its primary purpose is to guide professionals through the basic questions relevant to child sexual abuse (CSA) counselling or the legal investigation in a logical step by step fashion. It allows for the inclusion of information as it comes up throughout therapy. Second, it can be used as an efficient method of accountability in the maintenance of client files. Sexual abuse is a criminal offense and increasingly therapists are being required to write reports that are scrutinized in court in what some claim to be the "hysteria" of a child sexual abuse epidemic. Third, SAIR can act as a prototype for the purposes of ongoing research in the area of sexual abuse by providing consistently defined variables (items). Finally, it contributes to a realistic social awareness of the prevalence and consequences of phenomena associated with CSA.

SAIR is divided into four main information areas: (a) demographics about the victim; (b) intergenerational abuse in the family genogram; (c) offender demographics and characteristics associated with the abuse; and (d) resulting sequelae at the time of counselling. The reliability and validity of the items on SAIR are outlined through a series of steps in the development of the instrument, including its inception on 452 files on sexual abuse victims from the Victoria Child Sexual Abuse Society (VCSAS) in British Columbia.

This study explains the rationale behind the items chosen for SAIR and it discusses the results from its application on the sample. The thesis concludes with suggestions for further research on SAIR and calls for the formation of a collection agency to publish periodic reports of universal findings.

In the hysteria of the sexual abuse "epidemic" there are times when helping professionals long for a bit of order in the midst of the paper chaos, some direction in therapy when one is lost, a little insight and sanity in what seems an insane world. We look for peace in the likes of a friend or colleague, a vacation, a garden, a fresh bagel, or a new book. It is hoped that the Sexual Abuse Information Record (SAIR) will be useful for counsellors who work with victims of sexual abuse, and in that way, provide a little reprieve from the worry of ever growing accountability inherent in the controversial and demanding task of counselling victims of sexual abuse.

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Chapter One
INTRODUCTION

Purpose of the Study

The purpose of this study is to develop an instrument called the Sexual Abuse Information Record (SAIR) which would be helpful for professionals who work with victims of child sexual abuse (CSA). The process of developing SAIR takes place in three phases. The first phase requires a review of the literature on CSA in order to generate the framework and basic constructs for SAIR. The second phase refines the items generated for SAIR by using a sample of files from sexually abused victims who received counselling at the Victoria Child Sexual Abuse Society (VCSAS) in Victoria, British Columbia. Final revisions to SAIR take place during the third phase of SAIR development. This phase involves coding data for computer input and several professional consultations. This thesis describes each of these three developmental phases in detail. The final version of SAIR appears in Appendix A.

There are a number of benefits to be gained from an instrument such as the one proposed for this study. Many professionals working privately or in agencies and institutions may not be aware of the numerous factors that often operate covertly before, during, and following the incident(s) of child sexual abuse. By neglecting to ask crucial questions of the victim and of his or her significant others (i.e., secondary victims), the professional may be unable to respond to the needs of the client in an efficient yet compassionate manner. Conversely, those counsellors of CSA who are aware of the issues that may be affecting a victim's clinical presentation are more likely to be able to properly assess the situation and therefore, enhance the therapeutic process. Thus, the primary role of SAIR is to guide professionals through the issues often inherent in CSA, thereby providing an adequate assessment and therapeutic response.

Another consideration in developing an instrument to record phenomena associated with sexual abuse (SA) is the ever increasing demand for professionals working in this area to become accountable for their actions and reporting procedures. Some counsellors, especially those involved with custody and access disputes, are becoming involved in litigation over the possibility of false allegations of CSA. Therefore, a record of accountability is a second important aspect to consider when designing a SA information form since it is one method of efficiently keeping a record of the facts behind an allegation and the presenting sequelae of the victim. In this regard, it also may be useful for police or child welfare workers involved in an investigation of CSA.

Another potential benefit arising from the construction of this instrument is its use as an effective research tool in the collection of relevant data for ongoing research into issues associated with CSA. By providing an instrument that can be used in a variety of settings by different professionals, researchers could collect data in a consistent fashion (i.e., record information according to the same definitional constructs). This improvement over existing conditions (i.e., lack of a standardized SA information record) would greatly enhance the generalizability of results from one study to another.

The final major consideration in developing this record is the bias that exists in the literature due to both underreporting and the use of clinical samples. It would be beneficial to design an instrument that is relevant for a wide variety of populations including those who might not otherwise report their victim or offender information (e.g., male adolescents in group homes, young offenders, target populations such as those with disabilities or various ethnic groups). Thus, a final goal for the development of SAIR is to select appropriate items to efficiently cover a vast expanse of possible information retrieval.

Format of the Sexual Abuse Information Record (SAIR)

The goal of this thesis is to develop a handy fold-out sexual abuse information instrument (SAIR) that can be used to record SA data in four distinct sections, (Parts A, B, C, and D), each with its own distinct categories. Items in Part A will be required to tap information concerned with the general demographics of the victim such as the age and gender of the victim, the region of residence where the abuse took place, the number of offenders experienced by the victim, how the abuse was disclosed or discovered, and the reason that the abuse terminated. In addition, Part A will also record data concerning the victim's family such as the number of siblings, birth order of the victim, and the relationship status of the victim's biological parents at the time of abuse and again during counselling. These items will provide a way of recording victim demographic data so that it would be possible to research information on the clientele at a particular site such as the mean age of the clients, the number of males versus females receiving counselling, the average duration of abuse, and the stability of the home situation pertaining to multiple relationships of the parent(s).

Items in Part B also will concern family demographics, except this section only records information related to abuse in the family genogram. This part, therefore, includes information on the victim's relatives such as his or her parents or step parents, grandparents, aunts, and uncles. The information on relatives includes both victims and perpetrators of four categories of abuse: sexual, physical, emotional, and neglect. In this study, the genogram information on relatives is termed "historical" abuse to distinguish it from the victim's own abuse. The categories of items for Part B require developing to explore the possibility of patterns in intergenerational abuse.

Part C is concerned with the demographics of the offender as well as circumstances surrounding the abuse. Because some victims have more than one offender, this section needs to be repeated as often as necessary in order to record all pertinent information on each offender and incident(s). Questions asked pertain to the offender's age, gender, disabilities, education and employment, relationship status, addictions, concurrent abuse tactics, patterns in time and place associated with the abuse, relationship to the victim, degree of sexual intrusiveness, whether the abuse was reported and by whom, and the current state of the criminal investigation. The purpose of items for Part C is to gain as much information about the offender and his or her tactics in order to learn more about circumstances and possible patterns that play a role in creating a sexual abuse scenario. Also of interest is the percentage of reported incidents and the outcome of a criminal investigation of the alleged child sexual offender.

Part D of SAIR will be concerned with the outcome of the abuse on the victim. Numerous items thought to be associated with the trauma of sexual abuse, herein referred to as "sequelae," will be divided into seven sections as follows: school, work, or social activities; personal relationships; sexuality; bedtime; hygiene; behavioral or emotional symptoms; and medical or somatic complaints. SAIR requires this section for two reasons. First, questions in this section must determine whether these types of sequelae do exist and, if so, to what extent. Sequelae could be monitored for both initial and ongoing assessment in counselling. Second, to determine if there are possible relationships between sequelae and other variables such as the gender and age of the victim, the duration of the abuse, additional concurrent abuse, and the relationship between the offender and the victim.

Selected items for SAIR will reflect relevant variables related to the CSA phenomenon. Relevant variables refer to those characteristics inherent in an investigation of CSA and include both discrete variables (age or gender), continuous variables (anger, fears, or depression), and poorly defined variables (intrafamilial and extrafamilial CSA categories). The purpose of including constructs that have been inconsistently defined in past research is three-fold: (a) to set the criteria for how variables could be defined in the future, (b) to investigate the possibility of both short- and long-term patterns of sequelae in various populations, and (c) to determine the possibility of discovering statistically significant patterns in the family genogram or in offender tactics and demographics that are common to the phenomenon of CSA.

Rationale for the Development of SAIR

Research on phenomena associated with child sexual abuse is fraught with controversy because often inherent with research on human beings are too many intervening variables for one to make definitive statements. In addition to this problem, many of the constructs used in research are inconsistently defined from one study to another, which makes it difficult for practitioners to generalize findings and apply them in the field. In light of these problems and other difficulties associated with CSA research, accurate assessment, and appropriate therapeutic interventions, there are a number of reasons for the development of SAIR. It will (a) assist practitioners in the understanding of what treatment interventions may be most effective for victims of CSA; (b) provide researchers of CSA phenomena with a tool that allows for consistent measures of data collection; (c) promote a realistic social awareness of the prevalence and consequences of child sexual abuse; and (d) aid professionals in keeping a record of accountability.

The rationale for each of these areas is understood best with an awarness of some of the problems faced by those interested in the phenomenon of CSA. Therefore, a short summary of these problems is presented within the corresponding rationale for the development of SAIR.

A. Use of SAIR as a Therapeutic Tool

Finkelhor (1986) provides a comprehensive list of the many common errors made in conducting adequate research studies in the area of sexual abuse treatment. Some of the problems appear to be inherent within the population. For example, most studies on child abuse have been retrospective (i.e., adult survivors are only now coming forward to disclose abuse that happened years ago). This calls into question both the validity of their memories and the impact of subsequent events following the abuse. Consideration needs to be given to the hypothesis that many of the effects of sexual abuse can be traced to its aftermath (e.g., Following disclosure, was the child believed or blamed? Was the child humiliated because the whole community heard about it?)

Furthermore, the degree of impairment of victims ranges from slight to severe. In making an assessment, one of the many problems confounding research in this area is that victims who are abused may be initially asymptomatic, but this does not mean that they have not been adversely affected. In a study by Kendall-Tackett (1991), four factors (age at onset of abuse, duration of abuse, whether the abuse was reported to law enforcement, and number of sexual acts) were significantly related to the number of years between the end of molestation and seeking treatment. Adults molested as children emerged in two distinct groups (i.e., early and late presenters for treatment). Those who came early for treatment had reported their abuse to law enforcement, were older when the abuse began, had an abuse of long duration, and experienced more sexual acts. The researcher states, "We make a mistake if we talk about which group was 'most severely' affected...especially if we conclude that the group that initially appears to be asymptomatic was not adversely affected. Once late presenters come to treatment, they may need immediate crisis care and show serious symptoms as well" (p. 492).

Research into CSA outcome patterns tie in with research on amnesia and appears to have useful models by which clinicians can understand some of the coping mechanisms used by survivors. Therefore, findings such as those of Kendall-Tackett also may be useful in determining approaches to treatment.

Another problem with validating sexual abuse treatments is that the most common kind of sample for impact and treatment outcome studies is the clinical group, which usually consists of patients at a mental health agency. Such narrow samples are not good for studying the general effects of sexual abuse because they tend to have an over inclusion of people with serious effects. Therefore, treatments based on assessment of serious cases may not be useful for a significant proportion of victims who have experienced CSA. In the rush to provide therapy for the overwhelming numbers of clients who appear to be suffering serious sequelae from early sexual abuse, many programs have been initiated with little, if any, empirical evidence to justify the approach. As an assessment tool SAIR could be used for assessment of persons who have been sexually abused as a child or adolescent. It also could be used for some sectors of the adult population such as those who have a mental age well below their chronological age and depend on caregivers for support or for those adults who wish to disclose their own childhood abuse. Using SAIR in the assessment of various populations may help to distinguish among target populations regarding their treatment needs. Differences in treatment interventions may be required for specific individuals or groups of individuals (e.g., those with difficulties related to learning disabilities, dissociation, anger or fear management, or low self-esteem).

A third related problem regarding assessment and subsequent treatment is that not enough attention has been paid to differences in sex, race, and to those victims with mental or physical disabilities. Also, there has been little research dealing with adolescents who abuse younger children both inside and outside their families and abuse by peers (i.e., children who are abused by other children their own age or younger). For these reasons, SAIR will contain variable categories that distinguish victims for differences in gender, age, ethnicity, type of mental or physical disability, and whether the abuse was intrafamilial or extrafamilial.

Treatment research also requires longitudinal studies with follow-ups greater than one year. Perhaps the most serious flaw in the methodology of measuring the effect of treatment on the sequelae of child sexual abuse is the consistent lack of a control group. Consequently, to date, there is virtually no empirical evidence that any particular type of psychological treatment (i.e., individual, family, or group) is more effective than any other form of treatment for victims of sexual abuse. Even when studies report success rates, it is unclear how individual client's symptoms varied at the start of the program, to what extent each client's symptoms were alleviated by the end of the treatment, and what specific intervention(s) may have taken place to have made change possible.

In response to these assessment and treatment issues, it is important for clinicians to keep an ongoing record of sequelae through an instrument such as SAIR. Monitoring changes in both the number and type of sequelae during the treatment process will provide feedback to the therapist as to the progress of therapy. These data might provide clues to better interventions if it could be determined that there was a significant difference in number or type of sequelae and a particular treatment over time. SAIR could also be used in longitudinal studies where sequelae were monitored over longer periods of time. This could be achieved by having a previous client report back to update his or her file record or the therapist might make a simple phone call and fill out SAIR to compare with previous sequelae data. Then these data could be compared with other factors related to the individual and the abusive incident(s) such as the age of the victim when the abuse occurred, duration of the abuse, number of offenders, and degree of support upon discovery or disclosure.

> Another potential use for SAIR in the investigation of assessment and treatment approaches is to compare the outcome of different kinds of abuse. It would be interesting to note if the sequelae were different for children who experienced physical, emotional, or neglectful abuse than for those who experienced sexual abuse. SAIR also could act as a tool for monitoring control groups of children who have no abusive experiences with those who have experienced SA. Certainly it would be interesting to compare non-victimized children with abused children of the same age to determine differences in frequencies of sequelae such as nightmares, enuresis, anger management, attention-seeking behavior and so on.

B. Use of SAIR for Consistent Measures in Data Collection

In a review of the literature, Wright (1992) summarizes some of the factors that contribute to misunderstandings, methodological problems, and contradictory findings in the research on CSA. These factors include the following:

Underreporting of child sexual abuse: The severe underreporting of sexual abuse cases, along with the considerable variance in incidence and prevalence reported in the literature, makes it difficult for researchers to obtain an accurate estimate of prevalence and incidence. If, however, we know there is underreporting, then some reports must not be "under" reports. It is highly unlikely that everyone who experiences CSA reports it to the proper authorities.

Use of assessment data: Assessment data used in most studies consist of test scores from standardized psychological tests such as the popular Minnesota Multiphasic Personality Inventory-Second Revision (MMPI-2). One problem with these tests involves people's needs to appear socially acceptable, which means that respondents tend to endorse socially desirable items. Another problem is that test results can be affected by the degree to which the respondent has repressed, dissociated, or denied disturbing past experiences. Typically, these psychological processes are high during the early phases of treatment. Timing, therefore, is an important factor to consider when administering tests. In addition, it may be argued whether any psychological test can be said to measure sexual abuse, or whether such an instrument can discriminate between sexual abuse and other forms of abuse.

Survey studies: Studies that use questionnaire data have several problems. Often the responses are retrospective because adult "survivors" provide information about abuse that occurred in their childhood. Memory distortion and selective recall limit these data. Also, survey studies vary considerably regarding the method of data collection (e.g., interviews over the phone versus meeting the respondent in person.) Methods of data collection and phraseology can affect both the quality and consistency of the information obtained. These problems are inherent in all self-report data since we only have what people tell us of their experience.

Problems with sampling procedures: Many sexual abuse studies use nonrandom sampling procedures and small sample sizes. These small samples often are from clinical populations that probably do not represent the general population. Often larger samples often come from researchers who use the convenience of the college population, but, again, this convenience sample is unlikely to represent the general population. While these difficulties might be understandable in sexual abuse research, they nonetheless inhibit generalization of findings.

Lack of consensus on the definition of terms: Common child sexual abuse terms are used inconsistently throughout the literature, and the definition of sexual abuse varies from study to study. Aside from problems with general semantics, the age criterion of what constitutes a child also varies. Some researchers set the cut-off age between childhood and adulthood at 14, others at 16, and still others at 18 years (Finkelhor, 1979; Russell, 1983; Sorrenti-Little, Bagley, & Robertson, 1984).

Diverse research origins: Child sexual abuse research originates from diverse fields of study. These various perspectives yield a plethora of theories and explanations about child sexual abuse. Methodology and variables selected for analysis also vary depending on the researcher's perspective. Starr, MacLean, and Keating (1991) state the problem well:

> A major concern of researchers attempting to understand the causes and correlates of child maltreatment, of clinicians interested in working with perpetrators and victims, and of policy makers desirous of implementing effective prevention programs is the degree to which maltreated children grow up to be either maltreating adults or to exhibit socially deleterious sequelae of abuse and neglect....It is important to note that it is difficult to make exact comparisons between studies because of differences in samples, methods, and the definitions of independent and dependent variables. (pp.1, 4)

As a counsellor and as a researcher, I certainly experienced difficulties with many of the inherent flaws in CSA research expressed above. However, the problems with poorly defined constructs, inconsistent data, and lack of generalizable results inspired the development of SAIR. While some may criticize this study for using a clinical sample, one goal of developing SAIR is to establish an assessment tool that will make it easier for future data collection of those victims who turn up in other populations such as school or peer counselling groups. Victims who are reluctant to disclose (e.g., adolescent males or adult survivors who fear the stigma attached to being a victim of CSA) may be more prone to record their own abuse incidents if it were to be done anonymously and efficiently.

Some researchers (e.g., Briere & Runtz, 1990) question whether there may be particular syndromes of abuse that are unique to various populations. SAIR is a simple tool to complete in a reasonably accurate and efficient manner. Therefore, researchers should be able to promote its use in various populations and obtain data which would be consistent in their definition of terms. Therefore, results could be compared across different populations.

C. Use of SAIR to Provide a Realistic Awareness of the Prevalence and Consequences of Child Sexual Abuse

The true prevalence of child sexual abuse (CSA) in Canada is unknown because of multiple factors such as the private nature of family interactions, individual response on the trauma continuum, flawed methodologies, and the lack of commonly accepted definitions for various categories of abuse. In addition, there appears to be little awareness by the general public that all forms of coercion involve violence (i.e., a perpetrator's disregard for another human being's personal integrity), no matter how little *physical* force is employed in the act. Consequently, statistics on incidence and other selected variables vary widely, not only internationally or federally, but also within regions of each province or territory. The most noted national study in Canada was carried out by the Badgley Commision (Committee on Sexual Offences Against Children and Youths, 1984), which reported that one out of every three females and one out of every five males will experience some form of sexual assault before the age of 18.

Similar statistics were found in the United States by Russell (1988) who conducted a paramount study in an effort to describe the incidence and prevalence of intrafamilial and extrafamilial childhood sexual abuse among female children in the San Francisco area. Using a probability sample generated from households selected by a polling research company, 930 women 18 years or older were selected to be interviewed by people who had 65 hours of training related to interviewing victims of childhood sexual abuse. The results of this first probability sample survey indicate an alarming prevalence of child sexual abuse in three areas: intrafamilial, extrafamilial, and experiences in both categories. The rates for both intrafamilial and extrafamilial CSA are very much higher than any previous study has led us to believe. The researcher concludes that there is no reason to believe that the sexual abuse of female children would be any more prevalent in San Francisco than any other American city of comparable size. Therefore, the results suggest that over one quarter of the American population of female children has experienced sexual abuse before the age of 14, and well over one third has experienced sexual abuse by the age of 18 years. Furthermore, this study confirms the fact that only a small proportion of cases ever gets reported to the police (2% of intrafamilial and 6% of extrafamilial child sexual abuse cases in this study). Russell concludes that it is imperative that the magnitude of this problem in the United States be addressed, and it is urgent that more effective preventative strategies be developed and implemented.

The revealing studies by the 1984 Badgley Commision in Canada and by Russell (1988) in the United States are unique research on the prevalence of CSA because they obtained their data by sampling the normal population through survey methods rather than by using samples of clinical populations for their statistics.

The results of these surveys are supported by recent literature (Horton, Johnson, Roundy, & Williams, 1990; Kilpatrick, 1992) which suggests that the real level of CSA is higher than most statistics indicate, since only reported incidents are counted and children and male survivors are reluctant to speak about their abuse. If we are to believe these studies, then truly, the crime of sexual abuse has reached epidemic proportions in North America.

Despite researchers and child advocates from various professions who claim CSA is underreported, there are those who claim the incidence of CSA is overreported. According to Gardner (1992), the hysteria of sexual abuse in North America began when the United States Congress passed The Child Abuse Prevention and Treatment Act (The Mondale Act) in 1973. This Act mandated child abuse reporting laws (i.e., made it a criminal offence for any individual to withold information concerning the reasonable suspicion, discovery, or disclosure of child sexual abuse) and provided federal funding for district attorneys to aid in the prosecution of child sex abuse, but no funding was allotted for defendants.

Confounding this prosecution phenomenon was the growth of the feminist movement. Increasing numbers of adult female survivors began to reveal their childhood sexual abuse. These revelations naturally led human rights advocates to recognize the need to speak on behalf of children who currently are being abused. More recently, a small but concerted effort has come from adult males who are taking the risk of disclosing their own childhood sexual victimization. Finally, other sectors of society, such as people with disabilities and Aboriginals, also are disclosing their experiences of sexual abuse.

With so many reports of childhood abuse, some skeptics question their validity (e.g., Gardner, 1992). Some claim that when the media reports huge percentages the reader tends to discredit the reality of these accounts. (e.g., A recent study in Ottawa reports that 80% of all college students have been sexually abused.) One could argue that by clumping all types of sexual abuse and degrees of resulting trauma into the overgeneralized term, "sexual abuse," the more serious assaults tend to be negated easily. It is as though one reaches a satiation point where the information no longer is meaningful. Therefore, it would be helpful to have the term "sexual abuse" refined into construct levels that remain consistent throughout the research over time. It is difficult to place acts of SA on a hierarchial continuum of emotional trauma experienced by the victim because trauma is a unique experience for every individual. However, there could be a continuum reflecting the degree of physical intrusiveness experienced by the victim. Such a continuum might range from no physical contact whatsoever (exhibitionism, obscene phone calls, exposure to pornography) to fondling, to oral sex, and on to vaginal and anal intercourse.

SAIR will be designed to make these distinctions in physical intrusiveness by dividing encounters of SA into four levels. These levels are: least intrusive sexual abuse (no physical contact); less intrusive sexual abuse (completed and attempted acts of touching clothed breasts, genitals, or other body areas considered private); intrusive sexual abuse (completed and attempted genital fondling, simulated intercourse, digital penetration); and very intrusive sexual abuse (completed and attempted vaginal or anal intercourse, cunnilingus, fellatio). The reason for creating these levels of physical intrusiveness in CSA is to refine the definition of SA in order to make it a more meaningful construct. Future reported statistics on the prevalence of CSA might mean more to researchers, practitioners, and laypersons if it were broken down into these four categories. By doing so, it also allows for the possibility of determining whether level of physical intrusiveness (referred to as type of SA on SAIR) may be related to the subsequent sequelae experienced by the victim.

D. Use of SAIR as an Ethical/Legal Record for Professional Accountability

There are two major ethical and legal areas of increasing concern and apprehension for professionals working in this difficult field. The first problem involves children who allege SA and are involved in a custody dispute by their parents. The second is adult survivors who retrieve memories of early childhood sexual abuse while in therapy and then proceed to confront their alleged offenders, many through the criminal legal process. Professionals with this clientele face an increasing probability of litigation by either the defence or, in some cases, by the victim, who, in retrospect, feels he or she was mislead by the counsellor. Gardner (1992) is cynical about the lack of professionalism in over zealous "advocates" and "therapists." He expresses himself sharply:

> Anyone who believes that people who refer to themselves as therapists are psychologically healthy is suffering with a delusion,...and anyone who believes that people who are therapists are adequately trained and that most of them know what they are doing is also entertaining a belief that is contradicted by reality....There is a sea of therapists out there who are "in practice," are self-styled and self-trained, and have not progressed along any of the aforementioned formal paths. I am certain that most of these people are incompetent and many are dangerous. But there are thousands who *have* trained within the aforementioned disciplines who have, in my opinion, little or no competence. Even within these formal disciplines, there are many schools of thought and a wide variety of therapeutic approaches with only limited scientific validity. Accordingly, it is predictable that a certain segment of these individuals will also be dangerous. (p. 652)

A serious matter in recent media reports on CSA allegations is the increasing polarization between practitioners who appear to unquestionably accept all reports of CSA and those who fail to see any validity to claims of CSA. This is particularly evident in cases where adult survivors retrieve memories of their CSA through spontaneous and unexpected flashbacks or during the therapeutic process. For example, Wakefield and Underwager, two of the founding members of the False Memory Syndrome Foundation (FMSF), openly denounce the legitimacy of memories by adult survivors who claim they were childhood victims of sexual assault. The FMSF is a rapidly expanding American lobby group whose membership consists mostly of parents who have been accused of child sexual abuse by their adult children. Related to this organization is another highly visible and reasonably successful group called Victims of Child Abuse Laws (VOCAL). Wakefield and Underwager, who tour North America, conceived this organization and create chapters of the society in major cities. Their recent book, Magic, Mischief, and Memories: Remembering Repressed Abuse (1992) attempts to discredit therapists who work in the area of sexual abuse by stating that clients are coerced into believing they have been sexually assaulted in childhood despite attempts to dissuade their therapists otherwise. While it is beneficial for well-meaning professionals to take note of their biases relating to the possibility of encouraging their clients in unfounded claims of CSA, it is also important for professionals to recognize some type of middle ground in the legitimacy of clients' claims.

There is another issue related to the "hysteria" attached to memory recall of past child sexual abuse. Recently, psychiatrists, psychotherapists, and counsellors have been faced with clients who claim to be currently experiencing or recovering memories of satanic and ritualistic abuse. Many of these victims suffer from severe post-traumatic stress disorders (e.g., flashbacks, self-mutilation, suicidal ideation, phobias) as well as the newly diagnosed dissociative disorders of multiple personalities and ego state dysfunction. Most professionals and lay persons find it difficult to accept the possibility of the proliferation of such heinous groups in society. Therapists are torn between believing their clients, who are visibly suffering from sequelae associated with abuse, and the scant to nonexistent evidence required to back up their clients' claims for legal prosecution of the alleged offenders. The increased prevalence of clients presenting with these types of scenarios can be exasperating for professionals who are met with skepticism from many of their colleagues.

Influential spokespersons and authors such as Gardner, who is Clinical Professor of Child Psychiatry at Columbia University, have encouraged those who claim to be falsely accused of a pedophilic sexual offence to initiate litigation and to report the "therapist" to his or her regulatory body, if one exists. Consequently, there is an increase in the number of therapists being reported to their professional bodies for unethical conduct, often by the dissatisfied partner involved in the legal decision. Although frightening in its intensity, this newly developing trend of increasing accountability and the possibility of having one's files subpoenaed, currently is a reality for caregivers of sexual abuse victims. SAIR will be an efficient method of recording relevant and ongoing information on each victim and the characteristics pertaining to the abusive situation. Therefore, it can act as part of a safety net in providing required documentation to legal or professional bodies.

Introduction Summary

The purpose of this study is to develop an instrument called the Sexual Abuse Information Record (SAIR). In order to test the items generated for SAIR and to determine the variables associated with child sexual abuse (CSA), a secondary purpose of this study is to pilot SAIR on a sample of 452 files of victims of CSA at the Victoria Child Sexual Abuse Society (VCSAS) in Victoria, British Columbia. Data collection occurs in the second phase of this three-part study on the development of SAIR. The development of each phase will be presented in this thesis along with the results from the data collected at VCSAS.

The design of SAIR will consist of four distinct parts for data collection. Items from Part A concern victim demographics, Part B reviews abuse in the family genogram, Part C lists offender demographics and facts about the sexual abuse incident(s), and Part D records the sequelae presented by the victim at the time of counselling.

The rationale for the development of SAIR is presented in this thesis through an analysis of the problems often inherent within research on CSA. These problems include the lack of generalizability of results from independent studies due to poorly defined constructs used in data collection, variations in methodologies, and the use of small nonrandom samples. These concerns make it difficult to determine the true prevalence of CSA in North America. While some researchers and practitioners cite the increased accounts of CSA by adult survivors and male victims as evidence for underreporting of CSA by victims due to the shame, fear, and stigma attached to disclosure, others focus on the increased accounts by adult survivors as the result of a modern day "hysteria" associated with CSA. Methods of memory retrieval employed in therapy, claims of heinous crimes of satanic abuse without legal evidence to support those claims, and false allegations from children of parents involved in custody disputes lead some people to question the validity of child sexual abuse altogether. As litigation over CSA increases, therapists are facing increasing accountability for their assessment and treatment methods.

The goal of the development of SAIR is to provide researchers, counsellors, and other professionals involved with child welfare and sexual abuse with a handy fold-out instrument that (a) will provide consistent, reliable, and valid data collection on phenomena associated with CSA; (b) provide a guideline for counsellors in the assessment and treatment of victims of CSA; (c) provide those working with victims with an accountable record of events concerning the abuse; and (d) provide the public with a realistic sense of the prevalence and consequences of CSA.

Chapter Two
REVIEW OF THE CONTROVERSIAL ISSUES IN THE CHILD SEXUAL ABUSE LITERATURE

Introduction to the Review of Literature

The purpose of this thesis was to develop the Sexual Abuse Information Form (SAIR) to aid professionals working with victims of child sexual abuse (CSA). SAIR was designed to provide reliable and valid data collection for research and accountability, to act as a therapeutic assessment and treatment tool, and to increase awareness of a realistic assessment of the prevalence of CSA.

A number of steps were taken to generate items for SAIR including a thorough review of the literature on child sexual abuse. This review includes perspectives on current child victims as well as from adult “survivors” who claim they were victims of sexual abuse (SA) in childhood.

The CSA literature is an area of high sensitivity that is fraught with difficulties and heavily criticized by researchers. Much of the criticism is levelled at the use of small nonrandom samples and case studies, the lack of well defined constructs, and the various methodologies employed in the research. The inconsistency in the research findings results in a perpetual cycle of confusion and frustration for many victims and professional helpers. Stereotypic beliefs are alive and well today. Some believe statements such as "males are always perpetrators and females are always victims," "most mothers collude in incestuous relationships," "handicapped women are less likely to be assaulted," "satanic ritual abuse (SRA) victims are possessed by the devil," and "all those who are abused will be damaged for life." (e.g., England & Thompson, 1988; Moskal, 1994). However, as Wright (1992) points out, "It is important to keep in mind the newness of the [research] area and the complexity of the topic" (p. 15).

It is difficult to know the actual prevalence of CSA, the range of abusive acts perpetuated on victims, the frequency of these acts, and the factors associated with varying degrees of trauma subsequently experienced by the victims. The surprisingly high incidence of child sexual abuse among college students and randomly selected adults suggest that most cases are never detected and remain untreated (Greene, 1988). Although there appears to be a profusion of studies and theories on CSA etiology, sequelae, and subsequent treatment approaches, few of these studies are definitive (Finkelhor, 1984, 1987). Therefore, it is not surprising to discover that confusion and controversy permeates professional journals and the nonprofessional literature on child sexual abuse.

Green (1988) states: "More systematic, controlled research designed to assess etiological factors, relevant demographic factors, and immediate and long-term effects of child sexual abuse is desperately needed in order to design syndrome-specific interventions for the growing numbers of sexual abuse victims" (p. 46).

It was necessary to cover a wide scope of phenomena associated with CSA so that items for SAIR could be generated. This coverage was done by reviewing the areas most often cited as a concern for researchers and practitioners. Hence, this review of literature is set around five themes of controversy which appear to cover the range of topics associated with CSA: (1) Controversy over the concept of child sexual abuse; (2) Controversy over incidence and prevalence; (3) Controversy over precipitating factors (patterns in the victim's family, vulnerable populations, offender tactics) and principles of abuse; (4) Controversy over the effects of CSA on victims and significant others; and (5) Controversy over the response by professionals in assessment and treatment of CSA victims.

Chapter Two
(Part One)

Controversy Over Perceptions of Child Sexual Abuse

A History of Definitional Problems

Since the beginning of the 1980s research on child sexual abuse (CSA) has been expanding at a phenomenal rate. Because of the huge variety of situational factors, such as family demographics, personal characteristics of both victims and offenders, and the various paradigms from which theorists and researchers approach the study of sexual abuse, confusion and controversy reign over the possible etiologies, incidence, short and long term effects, and the most appropriate treatment methods. One of the major problems in accurately assessing these issues is the lack of a consistent definition for what constitutes child sexual abuse. As Mrazek and Kempe (1981) state:

> Variations in values, beliefs, and practices pertaining to all aspects of sexuality have occurred throughout time....While sexual abuse of children has existed thoughout history and across cultures, whether such behavior was conceived of and defined as abuse has been dependent on the societal values of the particular period. (p. 5)

The authors quoted above claim that some adult-child sexual practices have occurred in a continuous cycle: perceived as *normal* in one period of history, then *immoral* in another, later as *criminal*, still later as *psychopathological*, and finally returning to normal (or at least tolerated) again - all depending on the zeitgeist of the times. Diane Schetky (1988) presents ample evidence of these various historical perspectives in her analysis of child sexual abuse in mythology, religion, and history. Although it does not fit Mrazek and Kempe's (1981) circular model, a fifth, and more recent, dimension to adult-child sexual practices has been noted by family therapists: adult-child sexual practices that self-perpetuate through a learned intergenerational pattern stemming from the dysfunctional family. Finally, a sixth way of conceptualizing and defining child sexual abuse is through the feminist perspective: adult-child sexual practices as a result of a patriarchial society in which men are perpetrators and females are victims. A brief overview of each follows:

Adult-Child Sexual Practices Perceived as Normal

"There's nothing either good or bad, but thinking makes it so."
-Shakespeare's Hamlet

As examples of this phenomenon, Mrazek and Kempe cite that in antiquity the child lived his or her early years in an atmosphere of acceptance of sexual practices between adults and children. In Greece and Rome, the community approved of adult men using slave boys for gratification. Also, boy brothels, castration, and anal intercourse between teachers and children were accepted common occurrences. However, this is not merely a phenomenon of the past contemporary organizations advocate the acceptance of adult-child sexual relations. For example, the Rene Guyon Society in California believes that incest is mutually beneficial to adult and child, that there can be consensual sex between child and adult, and that such sex can be a beautiful, loving experience, an initiation in which the child learns about sex from a caring adult. Their slogan, "Sex by year eight or else it's too late," is hailed by more than 2,500 members. The British Pedophile Information Exchange advocates the lowering of the age of consent for sex to age 4 (Mayer, 1985).

Gardner (1992), an American child psychiatrist and author on the hysteria of sexual abuse, states that he has never felt comfortable with the terms *natural* and *unnatural* when they apply to human sexual behavior. He feels the term *unnatural* applies to those variations in sexual behavior that have been considered unacceptable to a particular social group. Each society considers natural those particular forms of sexual behavior that are widely practiced and accepted and deems unnatural (at variance with God or Nature's purpose) those forms of sexual behavior that are atypical and by social convention "wrong," "bad," or "disgusting."

Sometimes sexual behavior that does not lead directly to procreation has been subsumed under the unnatural rubric. For example, provided the individual experiences distress about it, homosexuality is still listed as as a disorder in the 1994 American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). However, Gardner argues that homosexuality may be seen as a natural expression of sexuality as well. Although it does not directly contribute to the proliferation of life, it allows for both genetic and environmental contributions (e.g., more aggressive heterosexual males control the gene pool for future generations).

Adult-Child Sexual Practices Perceived as Immoral

Religious viewpoints of adult-child sexual relations varied at different periods of time in history. But, even during a particular historical period, attitudes about sexual practices with children appear to have been morally inconsistent. Ancient Jews who sodomized children were put to death by stoning, yet "copulation with younger children was not considered a sexual act and was punishable only by a whipping" (Mrazek & Kempe,1981, p. 7).

Christianity brought the notion of childhood innocence into being. Children were thought to be entirely without any sexual thoughts, feelings, or capacities: "This lead to a great deal of denial for children needing protection and it was not until the 17th century that the Catholic Church took a harsh stand against any sexual relations between adults and children, including parent-child and sibling incest" (Mrazek & Kempe, p. 7).

The pendulum swung in another direction when, in 1905, Freud developed his theory of "polymorphus perversity" of the human infant. His theory states that the infant will exhibit every form of sexual activity known to humanity (e.g., sucking their mother's breast or rubbing their genitals while they lie on their stomachs.) Orgastic pleasure creates a strong craving for gratification and is, therefore, the driving force behind procreation, but society suppresses those forms of pleasure that it considers unacceptable and allows expression of those it considers acceptable. However, residua of the unacceptable variations often press for expression and may be found in various aspects of adult sexuality, both typical and atypical. From this perspective, all expressions of sexuality are *natural* if one is defining the word as a sexual form of behavior that exists in human beings, regardless of the particular society's attitude toward that specific mode of sexual expression.

Gardner (1992) states, "There is good reason to believe that most, if not all, children have the capacity to reach orgasm at the time they are born" (p. 15). This attitude is a far cry from the early Christian idea of a completely asexual human infant.

Adult-Child Sexual Practices Perceived as Criminal

With the decline of the Church as the prevailing authoritarian body and the passage of time into another zeitgeist, sanctions against sexual involvement with children became matters for the judicial systems in most Western countries (Mrazek & Kempe,1981). Actual charges against adults who involve children in sexual acts have varied. What charge is used with a particular offender often depends on the evidence available and the likelihood of obtaining a conviction. Unfortunately, even though a charge might not accurately indicate the extent of the sexual involvement that has occurred, it stands because it is the easiest to prove. Even more unfortunate are the cases where no charge is laid because the child is too young or mentally or physically unable to verbalize what has happened or feels too threatened by his or her perpetrator to make a convincing statement to the proper authorities.

The fact that laws vary between and within countries makes a major contribution to the already muddled definition of which acts constitute childhood sexual abuse. For example, the literature abounds with inconsistent definitions for incest as laws and beliefs vary cross-culturally regarding what relationships are to be regarded as incestuous (e.g., deYoung, 1982; Dinsmore, 1991; Haugaard & Reppucci, 1988; Renshaw, 1982; Renvoize, 1982; Rush, 1980). At present, there is much confusion and misunderstanding in ordinary conversation among professionals and lay persons as well as in scientific studies. Some laws against incest include only close blood relatives, for example, sex between a father and daughter. Other laws against incest include relatives outside the immediate family, for example, sex with an aunt, cousin, or grandparent. Some laws state that anyone who acts as a substitute for a family member (e.g., step-father, foster brother, adoptive parent, common-law partner of child's parent) and is sexually acting out with a child is commiting an incestuous act. This latter definition is more likely to be a therapeutic definition than a legal one. Because different researchers use different definitions of incest and sexual abuse in their respective studies, it makes it impossible to reliably generalize their findings. As deYoung (1982) states: "The student of incest behavior will be both amazed and frustrated at the plethora of blatantly contradictory research conclusions which have been reached over the last fifty years" (p. 1). Mrazek and Kempe sum the situation up well: "With such cross-cultural variability in the laws regulating sexual practices between adults and children and the variability in the application of the laws, any international comparison of criminal statistics is of questionable value" (p. 8).

Adult-Child Sexual Practices Perceived as Psychopathological

Freud's initial work with his female clients led him to believe that the "hysterical" attack was a symbolic representation of a repressed sexual trauma. He believed that the patient had undergone a passive sexual experience in childhood, but this psychial experience could not find adequate discharge because the nervous system was incapable of dealing with it at that time. The experience was forgotten, but with puberty, the memory of it was reawakened (Briere, 1989). Freud was concerned about the implications of his original theory for the frequency of incest in his culture. He also feared rejection by his professional peers. In a letter to his friend and colleague, Wilhelm Fleiss, he lamented that "surely such widespread perversions against children are not probable" (quoted in

Masson, 1984, p. 108). But Freud took a sudden change of heart regarding the basis for his clients' incest reports. According to Herman (1981), his Oedipus theory "was not based on any new evidence from patients, but rather on Freud's own growing unwillingness to believe that licentious behavior on the part of fathers could be so widespread" (p. 10). In Freud's own words:

> Almost all my women patients told me that they had been seduced by their fathers. I was driven to recognize in the end that these reports were untrue and so came to understand that the hysterical symptoms are derived from phantasies and not from real occurences....It was only later that I was able to recognize in this phantasy of being seduced by the father the expression of the typical Oedipus complex in women. (Quoted in Rush, 1980, p. 83)

According to Briere (1989), Freud's theoretical misstep has had major implications for mental health practice since it "a) introduced a probably false (but nevertheless immensely popular) set of assumptions regarding the etiology of 'hysteria' and other psychological maladies and, b) set a precedent for following generations of pyschotherapists to disbelieve their clients' reports of childhood sexual victimization" (p. 34).

Mrazek and Kempe (1981) claim that the term *sexual deviance* focuses on adult sexual perversion whereas the term *child abuse* focuses on the child. The latter term is a recent development in the literature as the psychopathological perspective has tended to focus on the adult's social deviance, rehabilitation, and treatment, with little attention paid to the victims of the abuse. Previous to this trend, the child was considered only when thought to be the provoker or initiator of the sexual act. Indeed, there is substantial literature on the etiology of the offender, mostly as it pertains to males abusing females.

It was primarily Nicholas Groth, author of Men Who Rape: The Psychology of the Offender (1979a), who brought the concept of the male pedophile to public awareness. He describes the male pedophile as someone who sexually uses children to gratify his needs for power, love, and companionship. If he is "fixated," he relates to children almost exclusively since he has an infantile personality and is unable to relate to adults. If he is "regressed," he sexually abuses children when under emotional or psychological stress but usually interacts with age-appropriate companions. In short, "a regressed pedophile usually seeks to have his intimacy needs satisfied by an adult but under stress will seek out children, whereas a fixated pedophile almost exclusively satisfies intimacy needs with children" (Dinsmore, 1991, p. 14). Dinsmore takes great exception to this theory because Groth based his theory on a skewed prison population, which is only 1% of the perpetrator population (i.e., those in prison are only 1% of the 6% of offenders reported by incest survivors.) Dinsmore further cites the example that incest survivors themselves refute the pedophile theory when they consistently use such terms as *pillar of the community, respected breadwinners*, and the *deacon of the church* when describing the men who abused them. Dinsmore cautions that disturbed men are not the only ones who engage in the sexual abuse of children: "In fact, more commonly perpetrators are men who look quite normal" (p. 15).

Adult-Child Sexual Practices Perceived as an Intergenerational Pattern

The family systems theory on incest is currently the most widely accepted theory in the mental health field. Rather than viewing incest as the cause of the problems that are almost always associated with incestuous families, this theory sees incest as a symptom of an already dysfunctional family system. Haugaard and Reppucci (1988) explain:

> By their nature as a set of interacting individuals, families develop rules of behavior that govern the functioning of each individual and the family as a whole. Within some family systems, behaviors that are defined by society as abnormal occur in order to keep their system and rules of behavior consistent. As such, behaviors of individuals are not

> viewed as reflecting individual pathology but rather as attempts by the system to maintain its balance of behavior. Much as in other families a child might become anorexic or a parent might become alcoholic, in incestiuous families, the incest maintains the rules and boundaries to which the family has become accustomed. (p. 110)

Adult-Child Sexual Practices Perceived in a Patriarchial Society

Much of the early recognition of child sexual abuse came from clinicians in victim response programs for adult women who had been raped or assaulted. The feminist movement expanded rape crisis centers and transition houses for women who had escaped from their violent spouses or mates. Women told their stories in a safe environmentand a growing awareness of the prevalence of child sexual abuse began. The feminist movement defines child sexual abuse as a result of the basic inequality between the sexes that has been perpetrated throughout history by the patriarchal social system:

> Most men are taught openly or subtly that they have the right to have their sexual urges satisfied. The social system reinforces both this belief and the obligation of other family members to keep the father content. Incest occurs because the father feels justified in turning to his daughter for sex if it is unavailable from his wife. (Haguaard & Reppucci, 1988, p. 111)

In contrast to the family perspective, this perspective advocates individual interventions aimed at the offender since "he" is the one who has erred: "When the entire family is involved in therapy, the responsibility for the incest becomes incorrectly shared by all its members" (p. 113).

Summary of Definitional Problems

The term "child sexual abuse" is used widely by both professionals and lay people with the implicit understanding that the term has the same meaning for all. "As a result of this myth of shared meaning, almost any statistic or comment about child sexual abuse is accepted as if the phenomenon being described is uniquely defined. However, close examination reveals that nothing could be further from the truth" (Haguaard & Reppucci, 1988, p. 13).

Attempting to define "sexual abuse of children" is fraught with difficulties since all definitions are culture and time bound. They are not based on rigorous scientific inquiry but on values and beliefs of individuals, professional organizations, and societies at large. Even the term "child sexual abuse" is not universally accepted and can be interchanged with "sexual exploitation," "sexual assault," and "rape." It appears that the term "sexual abuse" is used by researchers to cover a multitude of vaguely defined acts by a myriad of perpetrators to a variety of victims. There is a continuum of sexually inappropriate behavior ranging from no physical contact, as in obscene phone calls and exhibitionism, to various acts of increasing violence and intrusiveness. These acts can be carried out by a variety of perpetrators, many of whom are in a position of trust or authority.

Because of the complexity of the subject and the recency of attention placed upon it, researchers have much to learn about the child sexual abuse phenomenon. Haguaard and Reppucci (1988) caution us that as consumers of this research we will not be able to get unimpeachable facts: "The victims of child sexual abuse form a heterogeneous group....Definitional clarity is a requirement for meaningful future work" (p. 371). For now, the consequences of the lack of such clarity is that we must always incorporate child sexual abuse research findings with a knowledge of their limitations. It appears that even basic assumptions, such as any sexual encounter with an adult is harmful to a child or therapy is beneficial to all victims of child sexual abuse, should not be accepted as undisputed fact.

Current Definitions of Paraphilia

A **paraphilia** is defined as a form of sexual expression that is atypical or "off the beaten track." The DSM-IV emphasizes that the paraphilic label is justified when the activity is the primary or one of the primary sources of sexual gratification for the individual. Below is a list of paraphilia types in the DSM-IV, along with a few additional ones added by Gardner (1992).

Coprophilia (Feces): The term coprophilia refers to the enhancement of sexual gratification by either defecating on or being defecated upon by one's partner. (This practice is related to sadomasochism, with the domination/submission and hostile release of "shitting on someone".)

Exhibitionism: The term exhibitionism refers to the exposure of one's genitals to an unsuspecting stranger.

Fetishism: The term fetishism refers to the use of nonliving objects to satisfy recurrent intense sexual urges and sexually arousing fantasies.

Frotteurism: The term frotteurism refers to touching and rubbing against a nonconsenting person.

Homosexuality: The term homosexuality refers to engaging in sexual practices with someone of the same sex. Although not recognized as a disorder by the DSM-IV unless it causes acute distress to the individual(s) engaging in the practice, Gardner (1992) argues it meets the criteria of a paraphilia because the sexual behavior is atypical of most members of society and because it does not directly serve procreative purposes.

Gardner also argues that the paraphilias are determined by their political rather than their psychiatric considerations. For example, he does not see the rationale for including homosexuality as a disorder when it occurs between an adult and a child, but when it occurs between consenting adults, it is considered acceptable by the DSM-IV.

Klismaphilia (Enemas): The term klismaphilia refers to the use of an enema for sexual pleasure ("An enema to the anus can be what the vibrator is to the vagina.")

Necrophilia (Corpses): The term necrophilia refers to the act of having sex with a dead body. (For obvious reasons, necrophilia is almost unknown in females.)

Partialism (Exclusive focus on part of body): The term partialism refers to when a particular part of the body becomes the primary source of gratification (e.g., a man's fetish for female breasts).

Pedophilia: The term pedophilia refers to a sexual act between an adult and a child. The perpetrator is at least 16 years old and at least 5 years older than the child.

Sexual Masochism: The term sexual masochism refers to the act of being humiliated, beaten, bound, or otherwise made to suffer to satisfy one's own sexual urges and fantasies.

Sexual Sadism: The term sexual sadism refers to the sexual arousal of the perpetrator while causing the victim to suffer psychologically or physically.

Sadomasochism: The term sadomasochism refers to a partnership where the parties are satisfied sexually by engaging in both of the above practices.

Telephone Scatologia (Lewdness): This term refers to the attempt to arouse someone by talking obscenely to the victim on the phone. The practice is usually done by a male who engages in masturbation while talking to the female victim.

Transvestic Fetishism: The term transvestic fetishism refers to the act of cross-dressing by a heterosexual male.

Urophilia (Urine): The term urophilia refers to sexual arousal by urinating on the "lover" and/or becoming excited by being urinated upon (may also include drinking the urine). This practice is analagous to coprophilia.

Voyeurism: The term voyeurism refers to the act of observing an unsuspecting person who is naked, in the process of disrobing or engaging in sexual activity.

Zoophilia (Animals): The term zoophilia refers to sexual gratification by hugging, cuddling, talking to animals, much like a child with a pet. Contrary to public opinion, zoophilics generally do not have intercourse with animals. Zoophilia represents a fixation at an earlier level of psychosexual development.

In the wake of the AIDS threat, some social agencies began to develop pamphlets and videos using the straight talk of "street people." New terms for sexual behaviors have become known to the general public because these atypical sexual behaviors are described as either increasing or decreasing the risk of contracting the AIDS virus. For example, the term *fisting* refers to the act of one's partner placing his or her fist up the vagina or anus for sexual pleasure. While this behavior is thought to occur mostly among adult male homosexuals, it may also be used as an act of coercion on others; therefore, it would constitute sexual and/or physical abuse. In either case, the term could also be added to the growing list of paraphilias.

Chapter Two
(Part Two)

Controversy Over Incidence and Developing Trends

Incidence and Prevalence

Two years ago, the Globe and Mail newspaper (Appelby, 1992) provided the results of violent-crime statistics collected from 13 police departments across Canada in the 4 years from 1988 through 1991. At least 40% of all reported sexual assaults are committed against children 11 years old or younger and another 40% are committed against young people ages 12 to 19. The statistics also show a grim pattern: the younger the victim, the more likely an assault will be sexual in nature. Among adults, less than 10% of attacks involve sex, but with children under the age of 12, 60% of all assaults are sexual.

Statistics Canada (Statscan) data are drawn from interviews with 43,000 victims, part of the new Uniform Crime Reporting survey inaugurated in 1991. The breakdown is the most detailed yet of violent crime in Canada. It includes information on the level of injury, location of the incident, ethnic origin of those involved, and relationship between them. Statscan data will not identify the 13 police departments whose input was the basis of the survey, except to say that in all cases they are in jurisdictions of one million people or less. The survey covers about 10% of all crime, but it is hoped that enough police forces will join within the next 3 or 4 years to acccount for approximately 85% of all reported crime.

The survey reveals that young girls are more vulnerable than young boys. Among children 11 and under who suffered assaults of any kind, 56% were girls and 44% boys. Assaults on adults were about equally divided between men and women. The data further reveals that the offender was mostly someone who was known and trusted by the victim. The assailant was a stranger in only 8% of the sex assault cases involving children. In 48% of the cases, it was a family member and a casual acquaintance in 37% of the cases. The myth that children should be aware primarily of strangers as potential abusers was further shattered by the recent B.C. Ministry of Health (Child and Youth Mental Health Services). The department recently provided some startling information in a report of their study on child molesters between 1985 and 1991. They found 2,500 B.C. children were sexually abused by 45 child molesters (i.e., an average of 70 child victims per offender). A further analysis of 30 of these molesters showed most multiple abusers offended for an average of 10 years while in a position of trust (e.g., teachers, "Big Brothers," church camp leaders, babysitters, scout leaders, lay ministers, and relatives or friends of the victims). Half of the multiple child abusers were professional men in responsible positions who gained the confidence of parents and children. In this study, boys were found to have been sexually abused more often than girls (Malcolm, 1992).

To establish a national perspective on sexual assault, the Canadian Advisory Council on the Status of Women compiled a revealing set of statistics in a fact sheet entitled "Sexual Assault" (1985). The following are some of their findings:

1. A woman is sexually assaulted by forced sexual intercourse every 17 minutes in Canada; a woman is sexually assaulted in many other ways every 6 minutes.
2. Sexual assault happens to one out of every five Canadian women at some point in their lives; one out of every 17 women is sexually assaulted by forced sexual intercourse at some point in her life.
3. In 1982, there were 16,012 sexual offences reported to the police in Canada. Of these, 3,633 were sexual assault involving forced sexual intercourse. However, studies reveal that only one in every 10 sexual offences is reported to police.
4. From 1969 to 1981, the number of reported sexual assaults involving forced sexual intercourse increased by 151%.
5. Victims of sexual assault involving forced sexual intercourse have ranged in age from 4 months to 92 years.
6. According to a 1981 study conducted in seven major Canadian cities, 90% of the victims of sexual assault were female. Their assailants were male.

7. Nearly 50% of all assailants who force their victims into sexual intercourse are married or living common-law at the time of the assault and are considered responsible members of the community.
8. Not all attackers are strangers; 67% of the time, women are assaulted by someone they know.
9. Approximately 80% of assaults happen in the home.
10. One fourth of all sexual assaults involving forced sexual intercourse make "legitimate" initial contact with the victim. Examples of ploys are requesting information or posing as maintenance people.
11. Approximately 49% of all sexual assaults and 18% of sexual assaults involving forced sexual intercourse occur in broad daylight.
12. Survivors of sexual assault suffer in many ways: 62% of victims of assault involving forced sexual intercourse are physically injured in the attack: 9% are beaten severely; 12% are threatened with a weapon; and 70% experience verbal threats.
13. In one out of every 12 reported sexual assaults involving forced sexual intercourse, the victim becomes pregnant as a result of the assault.

There are those, such as Tom Hay (research director for the National Institute for the Prevention of Child Abuse in Toronto), who suggest the real level of sexual abuse is higher than statistics indicate since only reported incidents are counted and children are reluctant to speak about their abuse. Current evidence of underreporting was found in a 1992 survey conducted by a New York based national survey research organization. In this study, female interviewers telephoned about 4,000 women and discovered that one in eight had been raped at least once. Based on these findings, the survey team estimates that approximately 12 million American women were raped when they were minors. But their estimate that 683,000 American women were raped in 1990 is five times higher than the Justice Department's National Crime Survey reported for that year. Combining the findings from the FBI's Crime Reports and the National Women's Study reveals that only 16% of rape victims report the attack to the police (Kilpatrick, 1992).

Futhermore, Wyatt (1985) found as many as 62% of women reported a history of childhood sexual abuse, and Gold (1986) reports that her sample of 106 female victims reported a total of 191 victimization experiences. This meant that there were one to five perpetrators involved with each victim. Studies such as these confirm that many sexual abuse victims never reach out and either disclose or appear for counselling because they no longer trust others and see therapists as potential exploiters of their pain. However, an increasing number of survivors of sexual abuse are speaking up and coming forward.

Most of the writings about sexual abuse has been about females: "The idea that large numbers of males are sexually victimized is actually fairly new" (Hunter, 1990, p. 26). Many researchers estimate that male victims of sexual assault are grossly underreported. Porter (1986) provides numerous examples of reports from both clinicians and the perpetrators themselves who support the theory of victimization of the sexes to be close-to-equal: "One adult heterosexual pedophile, now incarcerated, attests to the pervasiveness of unreported young male victims. Sodomized by his grandfather when he was 10 years of age, as an adult he raped many hundreds of boys anally, including 200 boys in a single summer" (p. 5).

In summary, recent studies have begun to examine the prevalence of childhood sexual abuse as well as the presence of risk factors for the occurrence of abuse. As in the case of attempting to find a consistent definition of abuse, prevalence rates vary from study to study depending on the segment of the population studied (e.g., clinical versus non clinical, intrafamilial versus extrafamilial) and the definition of abuse employed. Records held by police, community agencies, physicians, and therapists are all showing an increase in services requested as a result of sexual abuse. While many wonder if the actual incidence of abuse is increasing, others attribute the demand for services to the rise of the feminist and human rights movements, which developed throughout the 1970s and 1980s.

Developing Trends

Recently, the British Columbia government made an analysis of how it needed to respond to child sexual abuse. The report (Wachtel, 1991) provides an excellent summary of recent trends in sexual abuse that are appearing in many of our communities. (However, it is unfortunate that there is a noticeable absence in the report's reference to special services required by persons with mental and physical disabilities.) The report calls for expanded services due to the increased presentation of victims: "The response system must command new skills and extend the range of approaches to deal with the variety of situations that are being identified" (p. 6). These trends can be summarized as follows:

More historical abuse disclosures: This trend is seen as a result of heightened public awareness and professional sensitization. However, there are those such as Gardner (1992) and the False Memory Syndrome Foundation (FMSF) who claim that allegations of CSA from adult survivors are out of control and in epidemic proportions due to the contamination of one's retrieved memories. Much of the blame for this contamination is thought to lie in the hype of media sensation. Gardner (1991) likens the zeitgeist of the current time in North America to the Salem Witch Trials of the 17th Century - a period when paranoia, hysteria, and scapegoating were rampant.

More young offenders: Today, there is less tendency to view sexual aggression by youths as a product of immature social skills or sexual experimentation gone wrong (Harvey, 1988). Increasing disclosure of "date rape" by female teens reflects this new attitude. Instead, sexual offending is seen as an habitual criminal pattern often established in youth (O'Shaughnessy, 1988). Indeed, the term *sexually acting out* is a source of concern for those professionals who provide therapy for victims. It is difficult to know when a child's sexually acting out behavior is a result of the child's own sexual victimization or whether it is perpetrator behavior.

More boys as victims and offenders: According to Finkelhor (1984), stereotypically, males are meant to be in control in all situations, to be the aggressor, to welcome sexual overtures, and so forth. Thus, boys' self-esteem and self-image are attacked by sexual victimization in ways that are somewhat different from girls, for example, having a fear of homosexual orientation. If the perpetrator is a male and the victim's body responds naturally to sexual stimulation, many young male victims fear they may have homosexual tendencies. In contrast, if the abuse is perpetrated by an adult female, the young male may also become homophobic if he did not welcome and enjoy the heterosexual experience. This places the young male victim in a vulnerable position, which is unique to male victimization, and which needs to be addressed in counselling.

More female offenders: Feminist theory helps make sense of the phenomenon of male offenders and suggests various programmatic approaches to deal with child sexual abuse (e.g., Rogers, 1990). Unfortunately, there is no comparatively developed theory that explains female offenders. While the number of female offenders is thought to be much lower than that of male offenders, it is significant enough to make this lack of explanatory perspective a problem for the response system.

Increasing recognition of females as perpetrators and males as victims is beginning to shake up old stereotypical beliefs that males are always the offenders and females the victims. Currently, increasing recognition of female sexual abuse is coming from four areas: males victimization studies, adolescent sex offender studies, studies of adult sex offenders, and recent clinical studies (e.g., Horton, Johnson, Roundy, & Williams, 1990). Groth (1979b) has argued that reported cases involving female perpetrators represent only the tip of the iceberg. On the other hand, Finkelhor & Russell (1984) dismiss the possibility that female child sexual abuse has been underreported as a "wave of speculation." The true extent of sexual abuse by women remains an issue of controversy. Regardless, "the needs of all victims of child sexual abuse should be considered, whether the abuser is female or male" (Horton, et al.,1990, p.122).

More very young victims: Greater public and professional awareness of child sexual abuse probably makes it more likely that victims, even very young ones, will be identified, but cases involving very young victims remain highly problematic for the response system. Child sexual abuse prevention programs, especially the school-based ones, arguably make school-aged children more aware of abuse and dangerous situations and, hopefully, more able to avoid or stop abuse by early reporting. Thus, it becomes more difficult for offenders to victimize school-aged children and increases their risk of being caught if they do abuse.

Similarily, justice system reform aimed at making it easier for children to testify against their abusers also presents an increased risk for offenders. However, there are strong traditions in our legal system (e.g., the right of the accused to confront his accusers, the emphasis at trial on a particular type of narrative ability) that tend to limit the opportunity for very young children to testify. Therefore, the younger the child, the greater the child's vulnerability. A fear within the response system is that offenders are increasingly concluding that a younger victim is a safer target. How to test child sexual abuse allegations, especially those made by little children, is a special issue today (Ceci, 1987; Faller, 1984; Jones & McGraw, 1987a; Yuille, 1988).

More ritual abuse cases: Ritual abuse increasingly is being recognized as a separate phenomenon within the spectrum of child abuse (although cases still generally fall to the child sexual abuse response system). Various adult survivor groups have sprung up (e.g., The Ritual Abuse Awareness Network Society [TRAANS] in British Columbia). Police organizations, especially in the United States, have gathered intelligence about "satanic cults." A task force in Vernon, B.C. is exploring the possible connections between drug trafficking and cult-like activity. Some private therapists are exploring treatment issues of persons who disclose ritual abuse victimization. The literature on cults, ritualism, satanism, and the consequences for members who are victims of abuse is growing at a phenomenal rate (e.g., Crewdson,1988; Finklehor, Williams, & Burns,1988; Fraser, 1990; Hudson, 1990; Young, Sachs, Braun, & Watkins, 1991). Unfortunately, as a new field of study in North America, much of the literature takes a polarized view of the existence of this form of CSA which makes it difficult to discern the legitimacy of its scope. Ritual abuse is addressed in Part Five of this review of literature.

Chapter Two
(Part Three)

Controversy Over "Precipitating Factors"

Patterns in the Victim's Family

In an effort to obtain an understanding of the factors involved in abusive incidents and the subsequent related sequelae, numerous studies have attempted to focus on classification schemes (e.g., Finkelhor & Browne, 1986; Groth, 1979a). These studies include assessing personal characteristics of offenders, victims, and parents or determining characteristics about the abusive incident itself, such as its duration, degree of coercion, and whether or not penetration occurred. These patterns will be addressed in this review of the literature.

Intergenerational Hypothesis

One apparent puzzle that is evident in incestuous families is the strong link between a mother having been abused in childhood and having children who themselves are sexually abused (Glaser & Frosh, 1988). This phenomenon has been labelled the *intergenerational hypothesis*. Because this pattern is so common in clinical populations, much of the research has focused on intrafamilial abuse and the dynamics of the family in incestuous cases. Regardless of the profusion of research on incest, Randolph & Nagle (1989) found that outcomes from studies on factors associated with intrafamilial abuse often are contradictory. In stark contrast, outside of theories on offender characteristics, the research literature lacks studies investigating potential factors that may be associated with extrafamilial child sexual abuse. Furthermore, studies that compare attributional factors among the two types of child sexual abuse are virtually nonexistent.

Gelinas (1988) provides a sound psychosocial theory for the perpetuation of CSA in the family genogram. She stresses that it is important to recognize the particular relational imbalances that exist within a family in which incest occurs. She states that incestuous sexual abuse of a child cannot develop in a family unless there are pervasive relational imbalances:

> For one or more members of a family to be thus exploited by another family member requires preexisting, long-standing relational patterns of unfairness, which progressively converge and focus on the child who becomes the primary victim....A child victim of incest is caught in a progressively more destructive system of unfairness, abusiveness, and isolation. (p. 25)

Furthermore, Gelinas reasons that the relational distortions in a family that necessarily precede incest continue to exist long after the victim has become an adult. The consequences are perpetuated as well:

> Whether the incest victim is still a child, or an adolescent living in the house at the time of disclosure or discovery, or is an adult living outside the family of origin, that family of origin will continue to treat her unfairly, and the forms of unfairness will be consistent through time. Any current adult relationships will tend to follow suit.
>
> Cessation of the sexual abuse does not stop the pattern of relational unfairness; these will continue in the victim's family and in her adult relationships. For these relational imbalances to change, they must be addressed and dealt with directly in the therapy. (Gelinas, 1988, p. 26)

The intergenerational hypothesis fits in a family therapy paradigm and explains a characteristic family constellation in which paternal incest occurs. The family pattern of dynamics is usually thought to be less of an expression of malevolence and more of complementary individual needs and weaknesses developing over time into a systematically exploitive family system over which no single person has control.

Parentification of children is a particularly important characteristic in this family constellation pattern. Gelinas (1988) explains that in this process the child is induced to assume and does assume premature and excessive caretaking responsibilites in her family. Not only does she perform certain tasks,(e.g., cooking, laundry, house or yard work, child care), she also has the responsibility for these functions. She is not expected to *help* with the cooking, she is expected to *do* the cooking; if she does not do the cooking, it does not get done. The parentified child internalizes her role of responsibility and gradually develops her identity in assuming care for others:

> Over time, she begins to meet the needs of other family members to the exclusion of her own. She forms a self-identity around the notion that she has responsibility for taking care of people and that they have no responsibility to care for her in return. Essentially, she has no right to reciprocity. As an adult, the parentified child will continue this unilateral caretaking style and self-identity. (Gelinas, 1988, p. 27)

In families where incest has developed, the mothers have usually been parentified children. In young adulthood, they are attracted by and tend to attract men for whom caretaking is important. Many of these men have experienced early maternal deprivation through death, depression, or divorce; they are relatively dependent, needy, and insecure. Consequently, these men respond to the caretaking role of the parentified woman each marries.

Despite the family-of-origin relationship imbalances that are mutually brought to the marriage or partnership, their own relationship imbalance works until the arrival of the first child. Having already been a surrogate parent to her siblings, parents, and spouse, the wife may feel depleted and somewhat ambivalent about having a child. Nevertheless, she shifts her caretaking toward the infant. While, to some extent, this is obviously appropriate, it also decreases the attention she can provide her husband. Also, because of the added stress she is under at this time, she depends on her husband for support, only to find that he is unavailable. He is having trouble himself. His wife is expecting support for herself and for him to take responsibility for his child, all the while withdrawing her caretaking of him. Not only is she "abandoning" him and placing new demands on him, but she is essentially producing his rival for affection.

As the wife tries to meet the growing demands on her limited time, energy, and emotional supplies, the husband becomes more demanding to have his needs met. For him, relationships mean "give," and he wants his wife to give him what he needs. For her, as a former parentified child, relationships mean "take," with nothing given back. Overwhelmed and resentful, the wife begins to avoid the husband as she is too confused to confront the problem directly. This pattern of increasing estrangement between the partners intensifies through time with subsequent births and family demands until the wife meets only the most pressing needs of the family. Depleted and unable to gain either assistance or emotional nurturance from her husband, she will attempt to gain assistance from a child as soon as possible. That child (usually the eldest daughter) will respond as best she can out of loyalty to her mother.

The mother usually begins to parentify the child around tasks. She needs help with child care and other family matters, in large part because her husband does not contribute his share in the family. Father, on the other hand, will tend to parentify daughter not to get tasks done, but to meet his own emotional needs. To have these needs met, father is "relationally pursuant." His wife is no longer available, so he may turn outside the family or he may turn inside the family, often to his eldest daughter. He will pursue her to meet his needs, usually for attention, affection, and especially nurturance. Thus begins a second generation of parentification by both parents.

In the family constellation described above, the mother's relationally avoidant stance and emotional depletion may mitigate against her pursuing information to uncover the incest. The father is rarely willing to disclose the situation and usually actively works to maintain the secrecy surrounding it, often by further splitting daughter from mother. Confusion by the daughter is inevitable. Even if she is old enough to recognize that what is going on is sexual behavior, as a parentified child, she has learned of her "lack of rights" to freely express herself. She has an avoidant and depleted mother and an abusive but needy father, and she is typically isolated from her siblings because her parentification is viewed by them as favoritism. Althogether, the family members occupy unenviable positions; the incest victim has the worst position of all.

In light of this situation, it is extremely difficult for the incest victim to disclose the abuse to authorities. Unfortunately, Gelinas (1988) believes that neither disclosure nor discovery change any of these relational patterns. If anything, they may be reinforced, and the various family members can be extremely unsupportive of the victim. This unfairness tends to continue through time, well into the victim's adulthood, and her feelings of obligation to take care of others without any reciprocal rights for nurturing are characteristically repeated in her adult relationships. This pattern of obligation, along with the damaged self-esteem that usually follows from sexual abuse, leads the incest survivor to expect and demand very little in relationships with others.

Other studies (e.g., Groth, 1982; Gelinas, 1983; Karpel, 1980; Karpel & Strauss, 1983) support the intergenerational theory and provide explanations relating to how the family secret and the persisting negative effects of incest are maintained over time.

The "Collusive" Mother: Myth or Monster?

There is a tendency to scapegoat mothers of incest victims as having cooperated in some way with the ongoing abuse. A consensus has developed that the mother almost always knows about the incest and, consciously or subconsciously, encourages the sexual relationship as a means of avoiding sexual relations with her husband. Images of the collusive mother continue to be strong in the literature and among practitioners who deal with incestuous families. The theory of the collusive mother actually blames the mother for the sexual abuse of her child.

Gilgun (1984) takes exception to this "myth" and insists that this accusation has minimal research support or therapeutic value. It also perpetuates the myth that the most common type of incest is committed by the victim's natural father, a myth that has been challenged by several research studies. She states that anonymous surveys of adults indicate father-daughter incest represents a fraction of all CSA situations and less than a quarter of all incest offences. Other male family members perpetuate most child sexual abuse.

Today's research is moving away from the stereotyping of males as perpetrators and females as victims and, as more male victims and female perpetrators come forth in therapy, it becomes increasingly difficult to accept simplistic categories of the etiology of sexual abuse. Instead, an awareness of the importance of unique factors in the relationship between the offender and his or her victim is more appropriate for therapy, but wreaks havoc for the reseacher who wishes to quantify his or her findings.

In a study of factors found to buffer intergenerational transmission of abuse, Egeland, Jocobvitz, and Stroufe (1988) report that mothers who are able to break the abusive cycle are more likely to have had a supportive nonabusive adult present during childhood, to have had extensive psychotherapy, and to have a satisfying, supportive relationship with their mates. Mothers who perpetrated the abusive cycle experienced more stress and were depressed, anxious, and immature.

The popular literature found in bookstores spares no reader from the explicit horror adult victims tell of their childhood abusive experiences, mostly within the family. Victim reports often confirm that different types of abuse exist together and that both parents are abusive. Indeed, the Canadian Centre for Justice Statistics (1991) reports that between 1980 and 1989 just as many children were killed by their mothers as by their fathers. One third of them were killed by their mothers, and one third of them were killed by their fathers.

Investigators at the Vancouver Women's Research Centre interviewed 25 adult females who had been sexually abused as children. One of these victims of paternal incest described physical assaults by her mother as "life threatening abuse" and cited examples of her mother chasing her, holding a knife to her neck, and "trying to hang me once," as well as violent sexual abuse:

> I have memories of my mother being sexually abusive. The reality of this is really different to me. It feels like a reactive thing to what was going on with my father. I remember being tied up, tied to a chair and being touched genitally. It was more punishing and humiliating. It feels like a reaction to my father having been incestuous. (Sleeth & Barnsley, 1989, p. 89)

This picture is a far cry from the relationally unbalanced, yet relatively "functional" family described by the intergenerational hypothesis, in which no individual is to blame. Instead, this perspective views the mother as unsupporting and cruel, and who deliberately ignores her daughter's pleas for help, no matter how blatant.

While all of the 25 mothers interviewed in the Women's Research study believed their children's disclosures, not all were able to respond appropriately: "In the process of getting help for their children, mothers themselves need support. Most of the women interviewed turned to family and friends first. They met with varied responses such as shock, disbelief, denial, and mother-blaming" (Sleeth & Barnsley, 1989, p.192). In the absence of support, women are particularly vulnerable to guilt and self-blame. Some women are castigated by social workers, police officers, judges, family members, and others. Blame seems to come from all angles: "Often a child will think a mother already knows about the abuse because mothers are assumed to have eyes in the back of their heads. Children think that a mother knows everything, and if she doesn't do anything to stop the abuse, they think she doesn't care" (p. 191).

Despite the lack of support, many mothers do respond as best they can following the disclosure or discovery of SA of their children. Gilgun (1984) found that none of the mothers of the 20 victims her team interviewed failed to take action when the abuse was disclosed.

Gardner's Criteria for CSA in the Family

The tremendous onslaught of criminal and civil law suits where CSA is a major issue is proof that many mothers are taking action after their children's SA accusations. Recently, Gardner (1992) published approximately 100 criteria to distinguish between true and false allegations of CSA in the family embroiled in a child custody dispute. One set of criteria concerns the perpetrator, whom he refers to as the father, one for the accuser (mother), and one for the child. It is interesting to note that many of the items appear to reflect the intergenerational hypothesis, regardless of whether the accusation is considered true or false. His first item for the mother criteria entitled, "Childhood history of having been sexually abused herself" is a good example of the seemingly incalculable factors that are inherent in SA research.

Gardner (1992) explains that mothers of children who have been sexually abused are more likely to have been sexually abused themselves in childhood than mothers who provide false accusations. It is as if sexual abuse "runs in the family." Some mothers who have been sexually abused in childhood may create situations that enhance the likelihood that their own children will become sexually abused. For example, sometimes the mother's abuse has resulted in sexual inhibition problems, resulting in her viewing sex as disgusting. She may often facilitate (consciously or unconsciously) her children serving as sexual substitutes in order to protect herself from involvement in sexual acts. A common complaint made by adult women survivors is that their mothers refused to listen to them when they complained. One factor operating in such unreceptivity to hearing about the child's abuse is the recognition that interfering with the child being abused by the father may create a situation in which the father turns to the mother for sexual gratification. Of course, other factors are operating (e.g., desire to maintain the marriage for status and economic security).

On the other hand, mothers who have been sexually abused as a child may also contribute to a false allegation. For such mothers, sex may be very much on their minds, and they may tend to interpret the most frivolous and inconsequential activities as strong indicators of bona fide sex abuse. They may be ever vigilant for signs of sexual molestation, and this preoccupation may fuel such misinterpretations. Furthermore, there may be psychological "unfinished business" regarding their reactions to their own childhood sexual experiences. For example, they may still harbor ongoing animosity toward the perpretarator and may readily displace such anger onto any man who provides them justification for such release. Accordingly, the opportunity to wreak vengeance on an abandoning husband can contribute to the formation of a false sex abuse accuation. The fantasy or delusion, of her husband having sex with her child may be a replay, down one generation, of her own experiences.

Vulnerable Populations

Disabled Children and Adults

Interest in child abuse and neglect that occurs in institutions and foster homes has increased in recent years (e.g., Finkelhor, Williams & Burns, 1988; Groze, 1990). To date, the focus of much research has been comparisons between in-home versus out-of-home maltreatment rates. For example, some researchers (Rabb & Rindfleisch, 1985) have suggested that despite a lack of public attention or official recognition of the problem, the complaint rates may be twice as high in out-of-home residential settings as those for children living with their own families. However, a 2 year study by Finkelhor et al. (1988) suggests that children may be less at risk in daycare centres than in their own homes. Obviously, reliable data about the extent of the problem remain elusive and comparisons of risk in various out-of-home settings are difficult.

Recent research provides evidence that individuals with mental or physical disabilities who spend time in residential care settings are at an increased risk for sexual victimization. For example, in a series of studies in the United States, Sullivan, Vernon, and Scanlan (1987) found that 50% of deaf children at a residential school reported sexual abuse. While statistical information on the true prevalence of CSA among the disabled is likely to remain unknown, Sobsey & Varnhagen (1988) estimate an increased risk of 50% for this population. To date, only one study appears to have found no evidence of an increased risk (Benedick, White, Wulff, & Hall, 1990).

Adults with disabilities are also at an increased risk for sexual abuse (Sobsey, Gray, Wells, Pyper, & Reimer-Heck, 1991). Davis (1989) found that 75% to 80% of mentally handicapped women from several community residences had been sexually assaulted. Blatt and Brown (1986) found that sexual abuse incidents were almost four times as common in institutional settings as in the community. More specifically, Turk and Brown (1992) argue that people with "communication problems" are especially vulnerable.

The University of Alberta Sexual Abuse and Disability Project surveyed 215 sexual abuse victims with disabiliites from a variety of service agencies in Canada, New Zealand, and the United States by mail and by phone over a five year period. About three fourths of the respondents had developmental disabilities, and one fourth had sensory, motor, or psychiatric disabilities. The survey reveals that approximately 90% of the abusers were male (Mansell & Sobsey, 1993). It also reports that despite the fact that sexually abused people with developmental disabilities experience considerable adverse effects from the trauma, most experience difficulty obtaining accessible, available, and appropriately adapted sexual abuse treatment.

The placement of a child in an out-of-home care setting is ostensibly society's way of meeting the needs of people with mental illness or mental retardation and unwanted children. In order to meet those needs, there are laws and regulations intended to ensure the safe and humane treatment of children in residential care. Unfortunately, these individuals are sometimes physically abused, neglected, exploited, and sexually misued by the people designated to care for them (Gil, 1982). Spencer & Knudsen (1992) report that children in daycare homes and centres and schools are less likely to be maltreated than those in foster homes, residential homes, or state institutions and hospitals.

This population is at particular risk as some pedophiles enter careers that bring them into close contact with probable victims, thereby providing opportunities for them to indulge in their deviant sexual impulses. Care providers on the staff of institutions, foster parents, and respite workers are typical examples of this type of career. Other examples include daycare workers, nursery or elementary school teachers, bus and taxi drivers, camp leaders, choir masters, and pediatricians.

A random sample of 510 reports of child abuse and neglect incidents in residential care settings was studied by Blatt (1992) in order to begin to develop a systematic understanding of the causes of such incidents. Findings indicate that the children allegedly maltreated in residential care settings are older than children abused and neglected in familial settings, that younger staff are more likely to be involved in incidents than older staff, and that male staff are more likely to be involved than female staff. Furthermore, incidents are more likely to occur between 5:00 p.m. and 9:00 a.m. and to be reported during 9:00 a.m. and 5:00 p.m. on weekdays.

The incidence and prevalence of caregivers who engage in perpetrator behavior is unknown and there is an urgent need for studies to determine factors inherent in these types of situations.

Aboriginal Peoples

Child sexual abuse is only now coming to be acknowledged as a special issue in native communities (e.g., Cowichan Band Council, 1988, McEvoy, 1990, Nimpkish Health Centre, 1989, Rogers, 1990). Aboriginal men and women are begining to speak out about the pervasive and long term child abuse they experienced both intrafamilially and extrafamilially, with many of the perpetrators in positions of moral or educational authority. The statistics are disturbing. For example, in 1990, it was found that over 90% of native women in prison have been physically and/or sexually abused (study on the impact of the criminal justice system on Aboriginal people in Alberta.) It is well known that substance abuse is a massive problem among the native populations across North America. Many professionals who are concerned about rampant substance abuse and CSA of native peoples fear that the AIDS virus will be introduced into the population of isolated or reserve children who are sexually abused (e.g., Moskal, 1991).

Martens, Daily, and Hodgson (1988) provide insight into the plight of native children who grow up and experience SA in communities where substance abuse is a major problem for teens and adults. Native children who come from "dually" affected families often have an even greater difficulty in disclosing their abuse and securing help in communities where the problem is rampant and where there are few healthy adults available for support. Martens et al. suggest that there is a strong level of denial of the dual nature of child abuse on the part of both the individual within the native community and the community itself. Therefore, it is difficult for native people to admit to their vulnerability and ask for mental health assistance, especially when it comes from white professionals outside the community. Figure 1 provides an understanding of the common defense mechanisms employed in both alcoholism and CSA. Each of the three defense strategies (minimizing, blaming, and rationalizing) have similar thought processes for substance abuse and sexual abuse. In order for the perpetrator to maintain a sense of personal control in real life situations, the ego distorts reality to justify the individual's behavior. This distorted pattern of thinking is readily transferred from one situation to the next.

Figure 1.

Some Defense Mechanisms Operating in Dually Affected Families

	Substance Abuse	Sexual Abuse
Minimizing	"I only had a couple of drinks."	"I only touched her a couple of times."
Blaming	"If my boss would get off my back I wouldn't drink."	"If my wife wasn't such a nag, I wouldn't have to turn to my child."
Rationalizing	"A few drinks helps calm my nerves and then I don't yell at anyone."	"My child and I both need affection and touching. Parents need to teach their own children about sex."

Offender Patterns in Pedophilia

The factors inherent in pedophilia are exhaustive. To simplify their explanation, this researcher places many of the phenomena associated with offenders of CSA in eight cateories which are, (a) history of famililly problems, (b) coercive, dominant types of pedophiles, (c) passive and regressive pedophiles (d) offender eccentricities, (e) vulnerable populations, (f) perpetrator tactics, (g) the continuum of coercion, and (h) the grooming process. These eight key concepts to understanding pedophilia are summed up at the end of this section with the13 principles of abuse determined by Finkelhor (1987). A brief explanation of each of the eight concepts follows:

History of Problems in Offender's Family

Many male and female adult pedophiles have a history of family influences conducive to the development of significant psychopathology (e.g., family violence, alcoholism, drug abuse, psychopathy, suicide). The more serious the family history of dysfunction, the more seriously disturbed an individual is likely to become; and pedophilia is one type of such disturbance. Commonly, the female pedophile comes from a dysfunctional home that has experienced a wide variety of unhealthy psychological influences, including alcoholism, drug and/or alcohol abuse, multiple divorces, violence, psychopathy, psychosis, suicide, and other manifestaions of family instability. Of 29 female incest offenders studied by McCarty (1986), 26 described a lack of nurturance in their family of origin. Eighty-five percent were married as teenagers, and 31 percent were 15 years or younger at the time of their marriage. All of the 16 female sexual offenders studied by Mathews, Matthews, and Speltz (1989) reported significant family difficulties, such as rigidity, inconsistency, and/or abuse. Money (1990) describes indifference and neglect as part of the family background of many pedophiles.

Pedophiles often have a longstanding history of emotional deprivation, especially in early family life. They may have been abandoned by one or both parents or grown up in homes where they were rejected or humiliated. Therefore, they seek the affection of children who are less likely to reject them and are more easily seduced into providing affection. Hence, females who are involved with incestuous relationships with their children generally are looking to achieve nonthreatening emotional stability. Many female pedophiles are significantly lonely women who are craving for affection. Krug (1989) studied eight men who were sexually abused by their mothers and found that the mothers were either divorced or had troubled marriages and were trying to compensate for their emotional privation by incestuous relationships with their sons.

Another pattern in the family history of the pedophile is that pedophiles are more likely to have been sexually abused in childhood than those who do not exhibit such behavior. It is part of the family pattern, and the pedophile may be the latest in a long line of sexually abused children, extending back many generations. Finkelhor (1986) states that "this [sexual abuse in childhood] is one of the most consistent findings of recent research." It is important to note, however, that "although most sexual offenders were themselves sexually victimized as children, most children who were sexually abused do not become sexual offenders" (Sgroi, 1989, p. 318).

Many female pedophiles have been subjected to sexual abuse, as well as physical and psychological abuse. Matthews, Mathews, and Speltz (1991) found that 15 of the 16 female sexual offenders they studied were victims of childhood sexual abuse, and many were also victims of physical abuse. Numerous studies support this finding (e.g., Faller, 1987; McCarty, 1986; Russell, 1986; Wyatt, 1985). Groth (1979a) believes that the former incest victim who becomes an offender does so in an effort to resolve the unresolved sexual trauma the individual experienced as a child. Of course, it is necessary to consider the learned behavior element of modeling one's parents.

Chemical dependency problems, including drugs and alcohol, are commonly seen among female pedophiles. In her study of 40 female sex abusers, Faller (1987) found that 55% of them had a history of substance abuse of alcohol and/or drugs. Likewise, Bess and Janssen (1982) report that 40% of the incest victims they studied reported alcoholism in their incestuous parents.

There are a number of studies that report a disproportionately high percentage of psychotics in the female pedophilic population. While Krug (1989) found no psychotics among the mothers of the eight men who were sexually abused by them as children, Travin, Cullin, and Protter (1990) found that most of the female sexual offenders they studied had a longstanding history of psychiatric disorder. Of the nine women studied by Rowan, Rowan, and Langelier (1990), all suffered from serious psychiatric disturbances, including schizophrenia, borderline personality disorder, and psychopathic personality disorder. Condy, Templer, Brown, and Veaco (1987) administered the Minnesota Multiphasic Personality Inventory (MMPI) to women inmates, some of whom were child molesters and some of whom were not. The scores of the sexually involved women were significantly higher than the nonsexually involved on the *schizophrenia* and *hypomania* scales but significantly lower on the *lie* scale. Seventy-five percent of the 40 female sex offenders studied by Faller (1987) were overly psychotic.

Coercive-Dominating Patterns in Pedophiles

Some pedophiles are very aggressive individuals. Cohen, Seghorn, and Calnas (1969) consider the aggressive offender to be one of three types of pedophiles, the other two types being the immature and the regressed. Ayalon (1984) considers the domineering type to be one of two types of pedophiles, the second type being the nonviolent type. There is often a family history of antisocial and even psychopathic behavior, and these family members serve as models for the pedophiles. Faller (1987) found that approximately 75% of the perpetrators in her study had significantly maltreated their victims in ways other than sexual abuse (e.g., physical neglect, physical abuse, emotional abuse).

This tendency to manipulate and coerce others into submitting to one's will may be an important ingredient in the pedophilic act. Some pedophiles are not so dominating that they *physically* overpower others in order to force them to submit to their desires; rather, they use *psychological* and *verbal* methods of getting others to submit to their wills.

Unlike male pedophiles, it is rare for female pedophiles to coerce or rape their victims. However, there are many female pedophiles who subject their victims to physical and emotional abuse and yet will use seductive and noncoercive methods to engage the children in sexual activities. Females who use force with their victims are in the minority. Accordingly, victims of female pedophiles are less likely to feel victimized or raped, especially in the case for boys. Lew (1990) states, "Sexual activity between older women and young boys is rarely treated as abusive." Several studies indicate that male victims are far less likely than females to view their childhood sexual experiences as traumatic and are far more likely than females to have positive recollections of their experiences (e.g., Condy et al., 1987; Fromuth & Burkhart, 1987). Aside from the decrease in aggressive sexual coercion by female perpetrators, there are other factors that may contribute to this phenomenon. One factor is social attitudes: women are likely to view the experience as rape and men as an initiation. In addition, the female is likely to be more physically traumatized.

Passive/Immature/Regressive Patterns in Pedophiles

Many pedophiles are inadequate individuals with few accomplishments. They commonly present with a history of poor school and work performance, unsuccessful marriages, and significant impairments in their ability to form age-appropriate friendships. They do not have the ego-strength to tolerate the inevitable rejections associated with age-appropriate heterosexual pursuit, and therefore, they may approach children for sexual gratification. The narcissism so frequently seen in pedophiles is compensatory for the underlying feelings of inadequacy. They have a strong craving to be loved and will gravitate toward children because children will so predictably be adoring of an adult who treats them kindly. Leahy (1991) states, "The most common diagnosis of the child abuser is that of narcissistic personality disorder." Peters (1976) found the offenders he studied to be suffering from deep feelings of inferiority and inadequacy. Medicus and Hopf (1990) state:

> Because of their small size, lack of experience, and sense of insecurity, children and adolescents of either sex do not arouse feelings of inferiority, fear, and anxiety in adult males. Thus, children and adolescents can become "sexual objects" for males who in sociosexual relations with adults feel inferior or anxious. (p. 141)

Overholser and Beck (1986) found many of the offenders they studied to be unassertive. Reasons for their pedophilia vary. Some of these types of individuals have intellectual impairments or serious psychiatric disturbances and are willing to engage in a wide variety of atypical or illegal behaviors in which they are coerced by more dominant individuals such as gang or group leaders. Others may be so inhibited that their pent-up impulses occasionally break out as the barriers become weakened by the strength of their primitive desires.

Women who feel inadequate are likely to fall into the "male-coercion" category of the female pedophile (i.e., women who perpetrate pedophilic acts in association with a domineering male lover upon whom they are dependent.) Such a woman may not get any pleasure out of the pedophilic act, but she will engage in it in order to satisfy her dominant partner. She may fear that if she does not comply with his demands she will lose him. Because of her feelings of inadequacy, she does not have the confidence that she can attract another man.

Many pedophiles are more comfortable relating to children because psychologically they are either fixated at or have regressed to earlier levels of development. Immature or passive pedophiles do not feel competent to pursue successfully heterosexual involvement with women their own age. Many studies indicate that pedophiles manifest this kind of anxiety with age-appropriate adult females (e.g., Johnston & Johnson, 1986; Segal & Marshall, 1985). The term *regressed pedophile* refers to a type of pedophile who has exhibited a reasonably normal heterosexual pattern and, then, under certain stressful circumstances, regresses to involvement in pedophilic behavior. In such cases, the pedophilic acts begin relatively late in the individual's life and are not present earlier. This type of pedophilia is thought to be far more amenable to psychotherapy than either the immature or aggressive pedophile (Cohen et al., 1969).

The regressed pedophile may have a past history of interest in age-appropriate women but, in response to stress, regresses to an interest in children. But even these individuals are likely to have a past history of sexual dysfunction or involvement in atypical sexual practices. Female pedophiles are more likely than males to regress to pedophilia after rejection and/or disappointment in adult heterosexual relationships. None of the 21 female offenders studied by McCarty (1986) preferred sexual relationships with children. In fact, McCarty found that about half of the incestuous mothers had a history of sexual promiscuity and/or prostitution. This is in contrast to male pedophiles who are less likely to have strong interest in traditional adult heterosexual relationships.

Egocentric Patterns of Pedophiles

People differ regarding their sexuality with respect to the kinds of partners they find sexually appealing, the kinds of activities they find erotically exciting, the frequency or intensity of their sexual desires, their attitudes toward their sexuality, and their abilities to control unwanted sexual desires. Sexual offenders differ from nonoffenders only in regard to certain aspects of their unconventional sexual interests or activities.

Individuals who are pedophiles generally do not exhibit their pedophilia in isolation from other sexual deviations. Abel, Becker, Cunningham-Rathner, Mittelman, and Rouleau (1988) found a wide variety of paraphilic sexual activities practiced by pedophiles (e.g., rape, exhibitionism, voyeurism, frottage, obscene mail, transexualism, transvestism, fetishism, sadism, masochism, homosexuality, obscene phone calling, public masturbation, beastiality, urolagnia, coprophilia.) Because paraphilias are much more common in males than in females, the presence of other sexual deviations is more likely to be found in the male than the female pedophile.

Another interesting phenomena associated with multiple deviant sexual impulses is a longstanding history of very stong sexual urges. While most adults date the onset of strong sexual urges to the pubertal period, pedophiles are more likely to date their sexual urges back even further. The age at which masturbation first began can provide important information: "This abnormally strong sexual drive is one of the reasons why the pedophile may be aroused by children of both sexes and even adults of both sexes" (Gardner, 1992, p. 54).

Yet another pattern of deviant behavior found among pedophiles is a large collection of child pornographic materials. The majority of pedophiles have large collections of child pornographic materials. They are often obsessed with their collections, and many have what can only be described as an insatiable desire to collect printed materials and videotapes. Postal officials know them well for the kinds of mail they receive, legally or illegally. Kinsey, Pomeroy, Martin, and Gebhard (1948) found collections of pornographic materials to be the most characterstic finding in their studies of known pedophiles.

Gardner (1992) cites men who involve themselves significantly with taking photographs or videotapes of children as highly suspect of CSA, especially if they are interested in photographing children in various stages of nudity. Although the pedophile may not involve himself any further with the children, the photographs are frequently used for masturbation. Lewis Carroll, a famous author believed to have been a pedophile, combined his pedophilia with phographing naked children (Bullough, 1983; Cohen, 1978).

In contrast to the pedophile whose deviant sexual impulses are consciously manifested through sexual images and ideas, some genuine pedophiles are rigidly moralistic and exhibit significant condemnation of those who "stray from the narrow path," especially in the sexual realm. Their preoccupation with the condemnation of those who might "stray" allows them to suppress their own inner impulses in the sexual realm. They demonstrate well the psychological principle of *reaction formation.* This is a process in which individuals vehemently condemn in others behavior that they might secretly (and often unconsciously) wish to engage in themselves, but cannot permit themselves to do, or to even recognize that they have the exact same inclinations. These pent-up impulses become strong, and when they break through, they might result in a pedophilic act.

Offenders With Intellectual Disabilities

There is a significant segment of the pedophilic population that must exhibit poor judgment in order to trust children not to reveal their sexual activities. Faller (1987) studied 40 female sexual abusers and found about one third (32.5%) of them to be retarded or brain damaged, conditions that gravely affected their judgment and impulse control. However, Larson, Maison, and Gilgun (1987) studied 12 female sex offenders and found none of them to be mentally disabled. In McCarty's 1986 study of sexually abusive mothers, about 40% were of borderline intelligence. In the same study, 56% of the co-offenders (women who committed incest in association with a male cohort) were of borderline intelligence.

Whether or not the average pedophile is of lower intelligence than those who do not engage in this practice is a controversial subject. Studies provide mixed results. It seems reasonable that people of low intellegence are less likely to appreciate the consequences of their atypical and illegal behavior and so are more likely to indulge in latent pedophilic impulses. Furthermore, their poor judgment increases the likelihood of getting caught. But history does provide examples of highly intelligent pedophiles. According to Money (1990), authors Lewis Carroll (Alice in Wonderland) and James Barries (Peter Pan) are two examples.

Another cognitive-behavioral pattern of pedophiles is that often they are impulsive. Finkelhor (1984) makes reference to impulsivity as one of the preconditions for pedophilia: "The potential offender had to overcome internal inhibitions against acting on that [pedophilic] motivation." In their review of literature, Hauggaard and Reppucci (1988) found poor impulse control to be one of the hallmarks of the male pedophile.

Perpetrator Tactics

Some theories on CSA suggest that children go along with the abuse willingly or unsuspectingly or innocently, unable to set or maintain personal boundaries. The Journal of Paedophilia is published biannually in The Netherlands for those who contend that children are sexual beings and sex with an adult is not, or not necessarily, terrifying or exploitive or damaging for a child but may actually benefit the child. However, in their interviews with 25 adult females who were victims of CSA or mothers of victims, the Vancouver Women's Research Centre found that nothing in these women's accounts supports this view. Although many of these women were physically abused as children in concurrence with their

SA (hit, punched, forcibly confined), women's accounts indicate that such generalizations of physical violence are dangerous myths. Certainly, there are many researchers who are aware of this myth. For example, Dinsmore (1991) argues that a child cannot consent to sex with an adult because of the very nature of the inherent power an adult possesses over a child: "Through manipulation, seduction, gifts, praise, and affection, an adult may give the child the impression that she has some choice in the matter; but a child does not have the ability to challenge someone more powerful than she" (p. 17). In order to understand how these tactics are employed by the perpetrator and why the victim responds to them, two key concepts are required. These concepts (the continuum of coercion and the grooming process) are explained below.

Continuum of Coercion

The continuum of coercion is difficult for many to understand because most people conceptualize violence as involving physical force, such as constraint, bullying, control, overpowering, or bondage in which the victim's feelings and responses of resistance or pain are overridden in the perpetrator's pursuit of what he or she wants. But child sexual abuse is inherently violent, whether or not the abuser uses outright physical force to get his or her way (i.e., the perpetrator is ignoring the fundamental rights of another individual). The forms of sexual intrusion vary: It is not always genital nor physical; nonetheless, the child is likely to be affected by the various forms of sexual intimidation. Stanko (1985) explains, "The father who fondles his genitals while he stares at his daughter as she undresses invades his child's feelings of security and safety. The father who progresses from fondling to intercourse uses a pattern of intimidation and control" (p. 23).

Sleeth and Barnsley (1989) explain further: "Perhaps from the abuser's perspective it is a matter of degree: if, for example, he doesn't actually rape the child or if he doesn't hit her, he may contend that he hasn't really hurt her. But from the child's perspective, it all hurts emotionally as well as physically" (p. 81). The child is vulnerable and easily manipulated because the continuum of coercion invoves a multiplicity of effective strategies, tactics, and manoeuvres that abusers employ to get their way, to use children as objects for sexual gratification. Children do not comply willingly. They do not initiate or choose the SA. Rather, they are coerced and manoeuvered into positions where they cannot refuse. What is found throughout adult survivor accounts is that when outright violence is not used by abusers it is either because they choose not to do it or because other tactics work better for them.

The Grooming Process

While there are numerous accounts of the abuser's outright use of physical violence, many children are confused by the abuser's power to name or disguise what is being done to them as something other than abuse. This is a poorly known, yet highly important phenomenon in CSA cases, and it bears explanation.

Abusers use varying means and degrees of violence to compel their victims to perform and endure sexual acts beyond the child's choice or physical capacity. Many adult survivors question themselves about the duration of the abuse and wonder why they were unable to stop it at some point, especially as they became older and continued to participate in the sexual act. They feel guilty, ashamed, betrayed and, most commonly, confused. They cannot understand the sexual conditioning or "brainwashing" phenomenon that this type of abuse entails. Friedman (1991) explains it well:

> It [grooming process] may be thought of as akin to a "breaking-in" period....Consciously or otherwise, the offender senses that a sudden sexual approach to the victim, without preparing the victim emotionally or cognitively, would be met with resistance, whether physical or emotional. This knowledge triggers a degree of anticipatory anxiety that is allayed by behavior intended to prepare the victim for abuse. This behavior gradually accustoms the victim to increasingly intrusive, inapppropriate sexual activities." (p. 27)

Hence, groomed from an early age to comply with the abuser's request, the victim is unable to perceive the pervasive abuse as abuse. The victim feels as though she was acting as an equal participant in a sexual relationship rather than succumbing to the offender's force and lessons of compliance. Sleeth and Barnsley (1989) provide another description of this grooming phenomenon:

> This taking on of responsibility is a particularly damaging and insidious by-product of abusers' skillful coercion and grooming of their victims. By twisting the definition of what he's doing, the abuser can manipulate the child's sense of what's going on and trap her into doing and believing what he wants. As a result, the child not only doesn't recognize the abuser's responsibility, she also can't see the abuse he's perpetrated. (p. 87)

Grooming can be accomplished using a number of disguises, for example, as a game, as punishment, as sex education, or as affection. Disguises reflect the abusers' attempts to avoid discovery by outsiders as well as to mask the abuse from victims. Disguises make it difficult for children to recognize the abuse and, thus, difficult for them to talk about it as abuse, or to be believed if they tell. One of the most damaging effects of disguises as a form of coercion is the child's confusion about whether the abuse was really wrong, or whether it was really abuse at all.

The 25 adult females in the Vancouver Women's Research Centre study provided many personal and revealing accounts of the aboved mentioned disguises. A few are provided below as examples of the insidious confusion found in CSA victims.

Game: Victims grow up in a sexualized atmosphere with messages that sexual "play" is not really abusive, that it is something to be tolerated rather than resisted. One account of abuse disguised as a game follows:

> I have a sense of being five or six. He kept licorice candy in his pants pockets and he used to get us to get it out of his pockets and he'd play games around that. He wore those pants that were loose and had big pockets. Sometimes we'd look in one pocket and there wouldn't be anything in it and we'd have to check the other pocket and then we'd find he had a hard-on. (Quoted in Barnsley & Sneeth, 1989, p. 97)

Punishment: The messages transmitted to children who are sexually abused under the guise of punishment are devastating. Some feel humiliation, sexual arousal, and pain all at once. One woman recounts being spanked as a child:

> [I was spanked as a child] in secret, with the bedroom doors closed, being forced to take my clothes or pants off and I usually got hit once but then he'd put his hand on me and hit his own hand so it sounded harder than it was. And then he'd fondle me....At other times I was spanked and fondled genitally at the same time. (Quoted in Barnsley & Sneeth, 1989, p. 99)

Sex Education: Abusers who take the sex education approach pretend to be teaching the child about sex. Often, they combine other tactics such as their use of authority with orders to keep it all quiet. The following account is from a woman who was SA by her father one evening when her mother was out visiting a relative. He told her he was going to give her sex education:

> He was sitting behind me. I was at the table and his chair was beside the fireplace. The next thing I know he's saying to me "have a look at it [his penis]." It was ugly. I didn't like it. I turned away....When he showed me his penis he was going to explain to me how you made babies. That was the preamble to it....He took me up to bed....I got in bed and he got in bed....I remember not liking it. Then mom came home and he was

> suddenly getting out of bed. (Quoted in Barnsley & Sneeth, 1989, p. 100)

Affection: Lack of affection is common in the family life of many survivors. In this study, some claimed they were "starved" for affection and were able to outline how the abuser played on their hunger and desire to please, how they pretended the abuse was an offering of affection. As children, there was no reference point from which to understand that they were being manipulated and that it was wrong. While several women described uneasiness as the abuser turned the affection they longed for into abuse, others said years passed before any such feelings emerged because they were told they were special and often treated with favoratism by the offender.

One woman remembers as a child directly asking her stepfather who was abusing her to stop "loving" her in this way:

> This one time he was lying naked next to me and it was really evident that he had a hard-on and I was sexually aroused. I was confused by what I was feeling inside. I thought that something wasn't normal about my sexual response. Up until then it had never been so intense....I said, "I don't want you to love me like this, I want you to love me like a father." His reply was: "I do love you like a father does, but stiff pricks have no conscience." So that really confused me. (Quoted in Barnsley & Sneeth, 1989, p. 104)

It is coercion when abusers use their authority, superior physical size, greater life experience, decision-making capabilities, and power to name what they do as something other than abuse and then blame their victims. Abuse disguised as affection has particularly insidious effects. Survivors are repeatedly thwarted in their attainment of the genuine love and caring that are the most basic of human needs.

Principles of Abuse

It is impossible to fully comprehend the factors behind the patterns and tactics noted above. Finkelhor (1984) determined 13 principles which appear to govern the perpetuation of abuse. At the Minnesota Women's Institute for Chemical Health in 1989, Larson presented a paper on these principles of abuse, neglect, and exploitation. These principles are based on the research literature of features commonly found in abusive families. These 13 very broad principles are worth considering as a summary of the general assumptions concerning victimizing relationships. As a cautionary note, these principles are limited as they can be safely made based only on the research thus far. The following list and commentary is paraphrased from Larson's paper. Portions relating to other forms of abuse and not pertaining to sexual abuse per se have been eliminated.

Principle #1: Abuse tends to gravitate toward the relationship of greatest power differential.

A good example is the most frequent form of reported incest (father-daughter), which has unequal power on two dimensions: first is gender, with males generally considered more powerful than females; and second is generation, with older being more powerful than younger. When abuse is considered outside the family, the pattern also holds true. The vast majority of rapists, exhibitionists, obscene phone-callers, and child molesters are male, again more powerful than the majority of their female victims.

Wolfe (1987) provides a profile of sociodemographic risk factors determined by two American studies on child abuse completed in the 1980s. With the exception of sexual abuse (where females comprise 85% of the victims), boys and girls are reported for physical abuse and neglect at approximately the same rate. In 97% of reported cases of child maltreatment parents are the perpetrators, with a large percentage being natural parents. It is noteworthy that natural parents, overall, are reported for less sexual abuse and more neglect than are other caregivers (such as stepparents, relatives, foster parents, and guardians), who commit more sexual and physical abuse.

Principle #2: Abusive acts seem to be carried out by abusers to compensate for their perceived lack or loss of power.

It is important to understand that this lack of power is at the level of the offender's *experience* and not a real lack of power. The literature suggests that male unemployment or financial difficulty are highly correlated with the beginning of sexual abuse in families. The situation with rapists suggests similar dynamics in that rapists tend to feel controlled by women. Again, it is not that they are in reality controlled by women, but rather, their experience of themselves in relation to women is one of inferiority and being dominated, especially in the sexual arena. The sexual attack is an attempt to rebalance power in the rapist's direction.

Principle #3: All forms of abuse occur in the context of psychological abuse and exploitation, commonly called *brainwashing*

The importance of this principle cannot be underestimated and represents one of the more fascinating aspects of the abusive systems. The subtlety of this interactive pattern is difficult to measure since the only part of the system that is influenced, albeit slowly and over time, is the victim's perception of reality. This is usually accomplished in childhood long before the child has an opportunity to develop enough "self" to resist the destructive conditioning. As discussed above, this process is known as "grooming" the victim and is found particularly in cases of father/daughter incest. Larson points out that the literature calls the process denial, but he feels this is an over-simplification of the issue since denial is not allowing the self to know what is real. This process requires constructing a new reality to replace the actual reality on a moment-by-moment basis. This dynamic process allows offenders and victims to tolerate the intolerable by diminishing anxiety, thereby allowing the individual to survive.

Principle #4: Allegiance to the perpetrator by the victim is often extremely strong in spite of the amount of damage inflicted.

A good example of this principle is how hostage Patty Hearst became a loyal advocate of her captors. Survival is a basic drive of the organism, and when the victims perceive a major threat to their survival, a primitive response engages that enables them to define the various avenues that might help them to succeed. In abusive families, where the family rules demand loyalty at all costs, it is only logical for victims to be extremely loyal and ally with their perpetrators.

Principle #5: Victims of abuse tend to be isolated in their shame and humiliation, believing they are the only ones to experience abuse or that the the abuse was their fault.

This is not surprising since victimizing families develop an overly rigid boundary around the family system, with safety and survival represented as available only within the family unit itself. Since outsiders are depicted as dangerous and enemies, little needs to be done within the family to reinforce the need for secrecy as protection from the outside world. Further protection and loyalty to the abusive family is seen in the victim's belief that the victimization is his or her fault, thereby proving to self and family that they do not pose a danger to its survival.

Principle #6: Abuse is more generic than was originally thought to be the case.

Ten to 15 years ago, it was assumed that men who sexually abused their own children would not molest outside the family. Current data indicate that while most incest offenders choose victims within their own family a proportion of them also molest nonrelative children as well. It was also assumed that offenders who maintained physical distance from their victims (e.g., obscene phone-callers or exhibitionists) would not also perpetrate physically intrusive sexual abuse such as rape. However, it is now known that a certain proportion of offenders in all categories will cross over to other types of sex offences, including patterns of escalation from nonviolent to violent sexual crimes.

Principle #7: The best predictor of future violence is a history of past violence.

According to Finkelhor's (1984) review of the literature, predictors of abuse can be placed on a hierarchy of past experiences. In order from highest to lowest risk, these experiences are: a) witnessing, receiving, or commiting violent acts in the home; b) violent acts toward pets or inanimate objects; c) having a criminal record of any kind (again suggesting that victim/perpetrator dynamics are more generic than previously considered); d) military service (not surprising since there is no "deconditioning" process upon leaving the service from a lethal training program); e) previous violent behavior toward women; and f) a history of temper tantrums as a child (an attempt to overpower by losing control).

Principle #8: There is no documented causal relationship between alcohol abuse and violence, but there seems to be a complex multilevel relationship.

The eighth principle seems surprising considering some of the data commonly associated with incest. However, in his book entitled Outpatient Treatment of Child Molesters, Friedman (1991) points out that the "myth of the cause" is a common misconception held by many people including child molesters themselves. There are a number of factors that contribute in various ways to child molestation; alcohol being one of them. But, it cannot be said to be the cause per se. Wolfe (1987) provides an overview of numerous studies that have demonstrated the correlational relationship between sociodemographic variables and rates of child abuse. These include environmental stressors affecting the family such as unemployment and economic difficulties, sickness or death, isolation from a social network, and poorly developed parenting or coping skills.

Sometimes the pedophilic act is committed under the influence of drugs or alcohol. It is then that the internal and external barriers that suppress pedophilic impulses are weakened and the individual engages in such behavior. These substances can also produce a state of amnesia for the pedophilic act(s), thereby lessening the guilt the individual might otherwise feel for having engaged in such behavior. Several studies support this claim (e.g., Hauggaard & Reppucci, 1988; Minneapolis Family Renewal Center, 1979; Peters, 1976; Sgroi, Porter, & Blick, 1982).

Alcohol abuse is also a common symptom of individuals who have been sexually abused. Victims often turn to alcohol and other drugs to medicate their emotions and to repress their memories. Some studies report that 60% to 80% of their treatment population of adult incest survivors are diagnosed as chemically dependent (e.g., Swink & Leveille, 1986). However, there is yet to be a definitive causal link between abuse of alcohol and perpetuation of sexual abuse.

Principle #9: Symptoms generally associated with different kinds of victimization have remained relatively stable during the past decade.

Included among these are depression, sleep and eating disturbances, anxiety, flashbacks, panic attacks, disturbed relationships, and suicidal thoughts and actions. While it was formerly believed that trauma inflicted by family members was most likely to produce symptomatic behavior, it now appears that the significant variable in post-traumatic stress is the victim's *experience* of the trauma, rather than specific characteristics of a traumatic situation. While Cicchetti and Rizley (1981) found that child abuse does not affect each victim in a predictable or consistent fashion, four symptoms commonly associated with incest victimization are sexual dysfunction, sexual acting out, self-mutilation, and chemical abuse.

Principle #10: Issues of family structure and male-female relationships are critical to the etiology of victim-perpetrator patterns.

The feminist perspective is clear on the notion that looking for individual characteristics of victims would not be useful in understanding the etiology of violence (e.g., characteristics of women who have been sexually abused when young as opposed to characteristics of women who were not abused). However, since individual characteristics are relatively easy to quantify, much of the research continues to look at these variables. It is more difficult to measure societal influences on male-female dynamics or the influence of sexual repression on individuals who later act out sexually or patterns of family interaction that facilitate abuse. Larson (1989) believes the next step in the understanding of abuse will be along more subtle lines. He states that in the 1970s, the tendency was to blame the victim for the abuse. Then in the 1980s, it was recognized that males are socialized to be perpetrators and females are socialized to be victims. Now, with the greater acceptance of systemic thinking, the relationship between victim and perpetrator is becoming the primary unit for study.

Principle #11: Women are socialized to be reactors, not proactors, and to be submissive in relationships rather than dominant.

Taken together, these qualities provide an operational definition for victim, namely "external locus of control." This powerful reactive/submissive stance precludes women from acting other than in a reactive way to perpetrating behavior. Similarily, males, who are socialized to be proactive and dominant, will feel victimized by women who are assertive, thereby increasing their perpetrating behavior in an attempt to maintain the balance. The pattern is circular, with both sexes needing to change their stereotypical behavior in order for patterns of interaction to emerge that are neither victim nor perpetrator. At present, treatment approaches that rely on acting on one's feelings simply would reinforce one or the other pattern, which explains why treatment for victims often results in failure or facilitation into the other part of the dialectic (perpetration). Although it might appear that the victim who turns perpetrator has opted for the more powerful stance, there is not a substantive change in the psychology of the victim.

Principle #12: The sexist orientation in our society, which fosters the premise that male supremacy must be upheld at any cost, would need to change in order for there to be substantive and consistent changes between men and women.

Men dominate this society in terms of political power, economic power, and the control they exert over women's bodies (Leidig, 1981). The social structure of a male dominated society renders many women powerless to protect themselves and their children from being sexually exploited (Herman, 1981; Russell, 1984). "A vicious cycle operating with respect to sexual abuse serves to increase the power of men over women and to create women who simultaneously fear men, overvalue and overidealize men because of their immense power, and are dependent on them" (Asher, 1988, P. 15).

The gender of the perpetrator appears to be an important consideration for type of child abuse. Based on 1982 statistics from the National Study on the Incidence and Severity of Child Abuse and Neglect completed in the United States, Wolfe (1987) remarks:

> The sex of the perpetrator is significant in terms of *type* of maltreatment, a fact that has been overlooked in part by the lack of investigations involving males. Males are associated with more physical abuse, the vast majority of sexual abuse, and less neglect than females....The perpetrator of physical abuse...was approximately 1.5 times more likely to be a male than a female. The finding of greater neglect among females may be linked to the greater likelihood of adverse socioeconomic factors, that is, when only the mother is present in the home, economic difficulties are more prevalent

> and child neglect emerges as the most common form of maltreatment. (p. 20)

Principle #13: Violence between men and women is inextricably linked with sexuality.

There seems to be a core condition in all of this discussion related to women having what men want (i.e., control over sex). Historically among humans, who engage in sex for purposes other than fertilization, women have been socialized to be in control of the "no" response and men to be in control of the "yes" response. Larson (1989) believes that women are trained to be in control (i.e., to limit their influence), and men are trained to be powerful (i.e., have the ability to shape, channel, or limit the influence of others).

Summary of Precipitating Factors

Children, teens, and adults in various vulnerable populations are coerced into sexual activity by many different types of offenders using various tactics and degress of coercion. It is only Naturally researchers look for plausible theories regarding the patterns that occur in the environment of both the victim and the perpetrator. But Sgroi (1989) warns us of the dangers of oversimplifying classifications and wryly notes, "Ultimately it may be that there are as many different reasons that SA occurs as there are persons who commit sexual abuse, and such propensity may drive from a combination of biological, developmental, psychological, and social influences" (p. 317).

Chapter Two
(Part Four)

Controversy Over Effects on Victims and Their Families

"Child abuse does not appear to affect each victim in a predictable or consistent fashion."
Cicchetti & Rizley (1981)

Trauma Continuum

Studies on the effects of child sexual abuse can be categorized in several ways. Individualized sequelae include immediate or short-term effects, long-term effects, effects of disclosure, reporting, going through the ordeal of the legal system, and internalized versus externalized effects. Research on family sequelae focuses on various members such as mothers of intrafamilial abuse, siblings, and parents of extrafamilial abuse. Needless to say, studies exist in all these areas.

Controversy in the literature rages not so much as to whether or not trauma occurs, but to what *extent* the trauma is experienced and how to identify and treat the factors that might mediate the sequelae:

> Although various symptoms have been reported to occur in the early aftermath of child sexual abuse, ambiguity exists as to which effects may be directly attributed to the abuse and which may be related to antecedent or concomitant variables. Also, there may be "sleeper" effects, of which the child and others are unaware, but which emerge with dramactic impact in adulthood." (Beitchman, Zucker, Hood, DaCosta, Akman, and Cassavia, 1992, p. 102)

The clinical literature suggests that examples of sleeper effects might include the development of serious subsequent problems such as sexual dysfunction, anorexia nervosa, prostitution, ego state and multiple personlaity disorders, suicidal ideation, flashbacks, and so forth.

Briere (1989) states that taken together the empirical and clinical literature on the long-term effect of childhood sexual abuse provides little doubt that such victimization can be quite harmful and long lasting:

> A sexually abusive environment usually hurts children and, in the absence of appropriate treatment, hurt children often grow to become hurt adults. The extent of this injury appears to be a function of a large number of variables, including type, duration, and frequency of abuse; interpersonal resources available to the victim; who the offender was (i.e., father, brother, teacher); when it occurred; how significant others responded to the abuse disclosure; and whether physical force was involved....Despite the complexity of such mediating variables, very few studies performed in the last 10 years show any form of childhood sexual abuse to be benign or harmless. (p. 29)

Indeed, there is growing evidence that the most serious long-term effects result from highly intrusive sexual abuse: For example, oral, anal, or vaginal penetration; abuse that is violent, forceful or sadistic in nature; abuse that continues over many years; and intrafamilial abuse, particularly when the perpetrator is a parent, step-parent, or parent figure (Browne & Finkelhor, 1986; Courtois, 1988; Herman, Russell, & Trocki, 1986).

Regehr (1990) points out that the literature is inattentive to the impact of *extrafamilial* child sexual assault on families. She states the reason for this is that "rape crisis centers tend to gear their services more toward adult victims, while child protection agencies are mandated to respond to cases where risk to the child (usually incest) continues to exist" (p. 113).

Green (1988) found that the age of the victim was one of the factors associated with a significant difference in trauma outcome. However, in their review of the long-term effects of CSA, Beitchman et al. (1992) found that the relation between age of onset of abuse and outcome is still equivocal. Greater long-term harm is found with abuse involving a father or stepfather and abuse involving penetration. Longer duration is associated with greater impact, and the use of force or intimidation is associated with greater harm. This supports the studies cited above.

The relationship of the victim and offender is thought to be of key importance because victims of incest experience a violation of trust by a family member. It is assumed that a victim of intrafamilial abuse will subsequently experience more emotional trauma than a victim of extrafamilial abuse. However, a recent study by Gregory-Bills (1989) compared three groups of women outpatients who were victims of intrafamilial sexual abuse, extrafamilial abuse, and those who had no victimization experiences. Her findings do not support the above assumption. Rather, both abuse groups had significantly more pathology than the group of women who had no victimization, but their pathologies were indistinguishable from each other. More research needs to be done in this area.

Following their extensive review of the literature on the initial and long-term effects of child sexual abuse, Finkelhor and Browne (1986) devised a conceptual model that divided all the common sequelae experienced by CSA victims into four categories. They propose that the experiences of sexual abuse can be systematically analyzed in terms of four trauma-causing factors (traumagenic dynamics). The authors argue that these dynamics "alter the child's cognitive and emotional orientation to the world, and create trauma by distorting a child's self-concept, worldview, and affective capacities" (p. 180). Table 1 shows the four characteristics a victim may experience from the trauma associated with CSA. These are (1) traumatic sexualization, (2) stigmatization, (3) betrayal, and (4) powerlessness. One or two examples of the inherent dynamics which created the trauma follow in the next column (e.g., problems with sexuality are due to the child being rewarded for sexual behavior inappropriate to his or her developmental level). The third column shows examples of the

Table 1.

Examples of the Traumagenic Dynamics Model in the Impact of Child Sexual Abuse (Finkelhor & Browne, 1986)

Result of Trauma	Inherent Dynamics	Psychological Impact	Behavioral Manifestation
Traumatic Sexualization	Child rewarded for sexual behavior inappropriate to developmental level	Confusion about sexual identity, norms, love, and affection Aversion to sex or intimacy	Promiscuity Prostitution Sexual dysfunctions-difficulty in arousal
Stigmatization	Offender blames and denigrates victim Shocked reaction by significant others	Guilt, shame, poor self-esteem Sense of being different from others	Isolation Drug or alcohol abuse Self-mutilation, suicide
Betrayal	Trust and vulnerability manipulated Child's well-being disregarded	Grief, depression Impaired ability to judge trustworthiness Anger, hostility	Clinging Vulnerability to revictimization Delinguency Marital problems
Powerlessness	Body invaded against child's wishes Offender uses force or trickery Repeated experience of fear Child unable to make others believe	Anxiety, fear Lowered sense of efficacy, perception of self as victim Need to control Identification with the aggressor	Nightmares,phobias Eating/sleeping disorders Dissociation School/work problems Bullying

psychological impact subsequently experienced by the victim (e.g., the victim may experience confusion about his or her sexual identity, the acceptable norms for sexuality in our society, and the difference between expressions of love and affection. The fourth column provides examples of the manifested behavior that commonly accompanies the psychological impact. In this example, the behavior is often promiscuity, prostitution, sexual dysfunction, or an aversion to sex. Considered together, the literature often refers to these trauma factors as the sequelae of child sexual abuse.

Wolfe (1987) points out that initial preconceptions of how abuse affects the developing child in both the short and the long term may have been overly simplistic and fatalistic. In particular, the impact of abuse on the child's development was assumed to be invariably negative and disruptive. However, researchers (e.g., Garmezy,1983; Rutter, 1983) found that children have a significant degree of *plasticity* in their adaptaton to stress. That is, a remarkable number of children seem capable of adapting successfully to extremely traumatic and stressful situations. However, a prime factor in how children respond to other forms of adversity and trauma during childhood (e.g., parental death or divorce, war, hospitalization), is based to a large degree on the behavior of their parents or other significant adults. Such adults appear to provide a model of efficacy for the child and an ability to exert control in the midst of confusion and upheaval. Hence, child abuse does not appear to affect each victim in a predictable or consistent fashion (Cicchetti & Rizley, 1981). Wolfe (1987) states:

> Some child victims emerge from very abusive families relatively unscathed, leading to the realization that the impact of abuse cannot always be detected in terms of its negative or undesirable influences on the child's development. Diverse outcomes are especially understandable when positive mediators of adjustment, such as supportive relatives or the child's coping abilities, are taken into consideration. (p. 98)

Finkelhor and Browne (1986) confirm findings of Garmezy (1983) that the response by significant others to a victim of CSA at the time of disclosure or discovery is a key factor in the degree of trauma subsequently experienced. This is a significant, yet often overlooked factor associated with SA traumatic aftereffects. Thus, it is important for those professionals who are working with children (e.g., teachers, childcare workers, counsellors, clergy, recreational staff) to know the facts about sexual abuse. Personal misconceptions and stereotypes that are inadvertently expressed to a victim upon his or her disclosure may very well have an adverse effect on a victim's willingness to seek out treatment and subsequently, on his or her recovery.

In preparation for understanding the impact of abuse on the child we can turn to the developmental literature that has investigated how the child's early experiences and adaptation may be either *directly* or *indirectly* connected to later psychological disorders. The research by Stroufe and Rutter (1984) provides a theoretical background. They emphasize that early experience may be directly connected to later disorders in any of three possible ways: (1) the experience leads to a disorder at the time, which then persists throughout the child's development, (2) the experience leads to bodily changes that influence later functioning, or (3) there are altered patterns of behavior at the time which only later on begin to take the form of a disorder. In a more indirect manner, early experiences can affect later psychological disorders by (4) changing the family circumstances which in time produce a disorder, (5) altering the child's sensitivities to stress management (coping style) which later on "predispose" the person to disorders or buffer against stress, (6) affecting the individual's self-concept or attitudes which influence his or her response to new situations, and (7) influencing the individual's selection of environments or the availablility of opportunities.

Sequelae

The traumatic effects resulting from violent crimes are often pervasive and serious. Facts released on violence and the Canadian family by the National Parole Board of Canada and by Statistics Canada (Statscan) in 1992 show that sexual assault raises the risk of attempted suicide in women from one in 50 to one in five. In addition, the Canadian Advisory Council on the Status of Women (1985) found that one out of every 12 reported rapes results in pregnancy for the victim. A woman is raped every 17 minutes in

Canada; a woman is sexually assaulted in many other ways every 6 minutes.

The exact number of women sexually abused as children is not known since the rates vary from 6% to 62% (Finkelhor, 1987). Rates vary considerably for males as well and range from 2.5% to 20% (Hunter, 1990). Many children are reluctant to reveal that they are being sexually abused, particularly if the abuse involves an ongoing relationship with a family member. Many victims of sexual abuse are too young to verbalize such information. Therefore, it is imperative that mental health and educational professionals be aware of the signs and symptoms of CSA.

It is clear that SA is a widespread problem with serious short-term and long-term sequelae. Young (1992) remarks:

> The apparent sequelae of severe sexual abuse make up a stunning range of psychological distress and impairment: dissociation, eating disorders, drug and alcohol abuse, self-mutilation, suicidal ideation and suicide, multiple personality disorder, borderline personality disorder, sexual dysfunctuion or disinterest, depression, anxiety, rage, poor self-esteem, guilt, social isolation, and vulnerability to revictimization. (p. 89)

To what extent the sequelae are due to sex abuse per se is still not known. Although various symptoms have been reported to occur in the early aftermath of child sexual abuse (e.g., Beitchman, Zucker, Hood, daCosta, & Akman, 1991; Browne & Finkelhor, 1986), ambiguity exists as to which effects may be directly attributed to the abuse and which may be related to "sleeper" effects (i.e., effects of which the child and others are unaware but which emerge with dramatic impact in adulthood. One such example is sexual dysfunction:

> Sexual dysfunction may not be evident as a short-term consequence of sexual abuse in the prepubertal child. In adults, however, healthy sexual functioning is considered to be an important component of adjustment. It should be recognized,

> then, that long-term effects of sexual abuse may manifest differently from short-term effects. (Beitchman, Zucker, Hood, daCosta, Akman, & Cassavia, 1992, p. 102)

A review of studies on the short-term and long-term effects of CSA has been compiled by Asher (1988). She reviews the effects of CSA on preschool children, school-age children, adolescents, and adults. A short overview of commonly found symptoms at these developmental stages is presented below.

Sequelae: Preschool Children

Fears, Tension, and Anxiety

Fear and anxiety are the symptoms most commonly reported in clinical studies for preschool children (Browne & Finkelhor, 1986). These fears include fear of punishment if the child reveals the secret, fear of not being believed, fear of being blamed, and fear of abandonment or rejection, that is, being separated from the family.

Children who have been subjected to frequent episodes of sexual abuse may become chronically fearful and tense. Such children exhibit the chronic state of hypervigilance and increased arousal described in the DSM-IV. They often present with an expression of what Goodwin (1987) refers to as "frozen watchfulness." These children not only exhibit the previously described fear of people of the same sex as the perpetrator (more often than not, men) but also fear situations similar to those in which the abuse occurred: bedrooms, bathrooms, showers, washrooms, and so forth. This situational fear, especially in younger children who are more helpless, relates to their feelings of impotence caused by being subjected to sexual abuse. Older children may be more fearful of the consequences if they disclose any hints of what they had been subjected to rather than to generalize it to an area or situation. They may fear that they will be murdered, beaten, or abandoned or that significant individuals in their lives will be subjected to similar consequences. They may fear a breakup of the family if they reveal the molestation. Such fears may result in a chronic state of timidity that is observed by friends, relatives, teachers, and neighbors.

Physical Complaints

Goodwin (1982) found that in 50% of incest cases reported to protective services, there was also evidence of physical abuse or neglect in the identified child or in siblings. Physical signs and complaints include sudden weight loss or gain, abdominal pain, vomiting, and urinary tract infections. While these are typical of other emotional disorders of childhood, perineal bruises and tears, pharyngneal infections, and sexually transmitted diseases (STD's) are more clearly indicative of sexual abuse.

Sexually abused children are also more likely to suffer with psychosomatic disorders. Their bodies have indeed been traumatized, and they may generalize from the genital trauma to other areas. In addition, tension and anxieties may have somatic components (e.g., nausea, vomiting, stomach aches).

Other Common Behaviors Following Child Sexual Abuse

Behavioral symptoms in young children can include sleep disturbances, nightmares, compulsive masturbation, precocious sex play, loss of toilet training, frequent bathing, crying with no provocation, staying indoors, and regressive behavior such as finger sucking or clinging (Asher, 1988). These behavior manifestations are generally interpreted as manifestations of fear and anxiety.

Putting the child to bed is commonly used as an opportunity to sexually abuse children. Not surprising, therefore, abused children may fear going to sleep. The tensions and anxieties associated with going to bed may contribute to the development of sleep disturbances. These include refusal to go to bed, insomnia, bedwetting, and nightmares. In addition, children who are being sexually abused at night are likely to have their sleep shortened, and they may awake tired and find it difficult to cope with daycare or school and other activities of the day. Other children sleep long hours as a way of removing themselves from the world.

Furthermore, children who have been sexually abused are likely to exhibit regressive behavior such as enuresis, encopresis, thumbsucking, baby talk, and separation anxieties. Having been psychologicallly traumatized at a higher level of development, they may regress to earlier levels in order to gain the securities attendant to these more primitive states.

Most of the findings described above are based on clinical studies where standardized instruments were not used. However, a study of156 children ages 4 to 6 who were sexually abused and tested using the Louisville Behavior Checklist. Gomes-Schwartz, Horowitz, & Sauzier (1985) compared the abused group to a normal group and a standard group of children using psychiatric services. In general, the sexually abused preschool children scored between the normal group and the psychologically disturbed group on the behavior checklist. The types of symptoms displayed by the abused children were consistent with the clinical studies cited above.

Sequelae: School-Age Children

The school-age child may exhibit many of the same symptoms as the younger child. Additional symptoms that may develop at this age include depression, insomnia, sudden school failure, truancy, running away from home, increased fear of being on the streets, and more negative feelings toward men (both strangers and known).

Gomes-Schwartz et al. (1985) found that 40% of their sample age 7 to 13 were seriously disturbed in one or more areas of functioning. As with the preschool children, the school-age children were generally more disturbed than the normal group but less disturbed than other children receiving psychiatric treatment. The school-age children exhibited some of the same behaviors as did the preschool children, such as fear and anxiety (45%), as well as immature behavior (40%). They differed from the preschool children in that they began to exhibit some aggressive, impulsive, and antisocial behaviors (45%).

School Attendance and Performance

Children who are being genuinely abused may often arrive at school early and leave late. Obviously, the school is being used as a refuge from the home. Schools can also provide an opportunity for peer contact that may be prohibited by the perpetrator (Sgroi et al., 1982). However, abused children whose perpetrator does not live in their home or those who are so disturbed by the abuse that they fail to attend school would not fall under this category. Sgroi et al. describe many other kinds of school problems that may be exhibited by sexually abused children: inability to relate to peers, impaired academic performance, sudden drops in academic performance, and inability to concentrate in school. Because the school situation is the most sensitive indicator of a child's psychopathology, and because it is one of the earliest areas in which psychological difficulties may manifest themselves, impaired school performance may be a very poor indicator of sex abuse:

> Because so many other kinds of problems may result in the same kinds of difficulties, I do not believe that the examiner does well to consider school performance difficulties as an important indicator. I am not saying that children who are sexually abused do not exhibit significant problems in school behavior; I am only saying that the school situation, because it is such a sensitive indicator of a wide variety of other psychological problems, is a poor criterion for differentiating between true and false sex abuse accusations. (Gardner, 1992, p. 178)

Sense of betrayal

Children who have been abused may suffer with deep seated feelings of having been betrayed. They feel betrayed by offenders because of their exploitation of them, and they may feel betrayed by their parents for not protecting them, especially in situations in which the parents did not provide them from protection from further abuse. Lourie and Blick (1987) describe this phenomenon: "Nonetheless, the children still feel betrayed. Someone whom the children have relied and in whom was placed a basic sense of trust has taken advantage of this dependency and trust in a destructive way" (p. 281). The children feel a loss of trust in the parent who has abused them, and the concomitant sense of betrayal may be devastating. Kaufman (1987) states, "The abuse serves to rob children of the small degree of personal power they may have, leaving them helpless and defenseless in a world in which they have also lost faith in their parents, their primary protectors" (p. 13). The younger the child, the less specific the child's description of such betrayal. It is only older children who will describe it, especially with regard to the unprotecting mother.

Withdrawal

Children who have been genuinely abused may often withdraw from involvement with others. They prefer a fantasy world that is safe and free from the traumas of their real life. Sgroi et al. (1982) state that many sexually abused children will escape their painful reality by withdrawing into fantasy. Frequently, they have a rich fantasy life that provides them with a pleasurable respite from their painful existences. Such withdrawal is observed in the interview and is described as existing in the home, in school, and elsewhere. In school, their teachers describe them as having little interest in learning and socialializing with their classmates. They are listless, wan, sad, and pathetic. They have few friends in their neighborhood, and they neither seek nor are sought by peers.

Abused children often withdraw from the abuser because of the trauma they anticipate when involved with him. They tend to generalize and assume that others, especially those of the same sex as the abuser, will subject them to sexual indignities as well. They may exhibit fear of going into washrooms, showers, and other places where sex abuse has taken place. There is a similarity between the withdrawal of the child who was sexually abused and the flinching of the child who has been physically abused. In both cases, the child feels relatively safe when a suspected individual is at a distance. Whereas the sexually abused child may move away at the approach of a suspected adult, a child who has been physically abused may recoil in fear, flinch, or make other head or hand movements suggestive of an attempt to protect oneself from being slapped or hit.

Sgroi et al. (1982) describe poor peer relationships as one manifestation of withdrawal. This may relate to the socialization of the abused child's family. Often, a controlling father will not permit his children to get together with others after school and on weekends. However, Gardner puts very little weight on this criteria as evidence for CSA because, like school performance difficulties, it is a sensitive indicator of a wide variety of other problems that have little or nothing to do with sex abuse.

Sense of Sexuality

Aside from the pseudomaturity developed by the parentified child, victims are often prematurely brought into a state of adult-level sexual excitation. They may talk frequently about sex, to the point of obsession. Somehow, sexual issues seem to come up in conversations, in the child's drawings, and associated stories. Such children may attempt to involve themselves sexually with other adults and/or children (e.g., pulling up someone's dress, trying to put their hands in someone's pants, rubbing their genitals against someone). Such abused children may develop an obsessive interest in looking at the genitals of others, male and female, adult and child. They may also appear quite seductive and exhibit a typical pattern of relatedness with the perpetrator such as giggling, grabbing, and excessive tickling.

This sexual excitation and pseudomaturity raises the serious question regarding the consequences of one's actions. That is, at what point does a victim's sexual pseudomaturity and acting out behavior transform into genuine offender behavior? Mitnick (1985) reports treating child victims as young as 4 years of age who have been inappropriately sexual or sexually abusive to someone more vulnerable.

Porter (1986) writes of research conducted with young male victims of sexual assault and is interested in this question. He notes that not all males who are sexually abused deal with their victimization by being sexually assaultive to others. Nevertheless, in sex-offender treatment programs, up to 100 percent of the offenders may report experiencing some type of early sexual victimization (Knopp, 1982, 1984, 1985).

Early sexual victimization without benefit of any therapeutic intervention is considered to be one contributing factor to the later sexually aggressive behavior of many adolescent and adult male sex offenders:

> The male victim of sexual abuse is more likely to turn his rage outward in aggressive and antisocial behavior. He is even more intolerant of his helplessness than the female victim....Child molestation and rape seem to be part of the legacy of rage endowed in the sexually abused boy." (Summit, 1983, p. 185)

Porter (1986) suggests that many juvenile male victim-offenders act out the same sexual offences perpetrated against them as an attempt to gain control over what took place with them: "Control is certainly a big issue to many of these victim-offenders. Maybe they did not have control in their own victimization, but they certainly had control when they were offending" (p.15). Reports from therapists (e.g., Lane and Beavers, 1985) contend that coming to terms with their own victimization is one of the most critical treatment issues for youthful sex offenders:

> Because as victims they were forced to submit to sexual abuse passively and helplessly, they developed a terror of feeling helpless or controlled in any manner or circumstance. Many of these victim-offenders react by making a decision that it will *never* happen to them again and generalize this reaction to any situation that remotely resembles the terrifying memory. Thus, they become overly defensive to being told what to do and frequently distort their perception of others, readily assuming that everyone is trying to control them. Perhaps because the youth himself felt so helpless at the time of his victimization he takes pleasure in making

> others feel similarly helpless and controlled. He seems to be saying to himself, "If I feel powerful, I must be OK." He then uses this to make himself feel less vulnerable to being victimized again. (quoted in Porter, 1986, p. 16)

Sequelae: Adolescents

As the child approaches adolescence, more antisocial behavior such as petty crimes, drug use, promiscuity, and prostitution are seen (de Young, 1982). Adolescents may run away in order to escape their intolerable situation or as a cry for help and as a way of calling attention to their dysfunctional families. Nearly one third of Herman's (1981) sample of 40 incest victims attempted to to run away from home as adolescents. When Gomes-Schwartz et al. (1985) found less psychopathology than expected among their sample of teenagers, they hypothesized that "the severity of their disturbed behavior may have caused them to run away or to be placed in mental health, corrections, or social welfare institutions" (p. 507). Thus, it was unlikely that severely disturbed teenagers would turn to a Family Crisis Program for help, which is where this study was conducted.

It is not uncommon for a runaway to turn to prostitution as a way of financially supporting herself. Silbert (1981) found that of 200 women prostitutes studied in the San Francisco area, 60% had been abused prior to age 16 by an average of two people each. Although most runaway incest victims fall into prostitution as a way of supporting themselves, many find they can tolerate the situation because it is the first time they can exert power over men. In addition, during their sexual contacts with the perpetrators they have learned to dissociate from what is happening to their bodies (Gelinas, 1983; Renvoize, 1982).

Depression

Depression is a symptom more commonly noted with regard to adolescents than with younger victims of sexual abuse. In deYoung's (1982) sample of 54 adolescents, 68% attempted suicide at least once with 50% making more than one attempt. The first attempt occurred either during the incest or within 2 years of its cessation.

Teens who have been sexually abused are often depressed, especially if they have been abused frequently over time, and especially if there have been terrible threats made regarding disclosure of their sexual experiences. The main manifestations of the depression may be depressive affect, loss of appetite, listlessness, loss of enjoyment in play and activities, impaired school curiosity and motivation, poor appetite, difficulty sleeping, and suicidal thoughts. The depression may be related to the feelings of betrayal engendered not only by the offender, but by the passivity or failure of others to protect the child and prevent a repetition of the abuse. Depression may be related to pent-up resentment that is not allowed expression lest the perpetrator carry through with the threats of retaliation.

Sexuality

When the incest-abused girl reaches her teenage years, she is increasingly at risk of the additional complication of pregnancy. Pregnancy, either by the incest perpetrator or by another male, is one way the daughter can exit the abusive relationship. In Herman's (1981) study of 40 incest victims, 45% had an adolescent pregnancy as compared with 15% of the control group. She noted that the pregnancies usually did result in ending the incestuous relationship.

Sexually abused children are often compliant. The perpetrator may have threatened that noncompliance will result in terrible consequences to themselves and their loved ones. Especially in situations where the perpetrator lives in the home, the child's life is controlled, both body and mind. The abusing father is a very domineering individual who subjects all members of the family to his demands and whims. Sexual abuse is just one manifestation of this subjugation. These children often develop compliant personalities out of fear of violence and/or rejection by the father. Many develop a cheerful facade that extends to inhibiting themselves from expressing dissatisfaction in any situation and contributes to their compliant behavior.

The risk of revictimization is a consequence of SA that has been documented for both children and adults. de Young (1982) found that 38% of her sample was sexually victimized by someone other than the original perpetrator either during or within 2 years of the incest. Russell's (1983) data indicate that repeated victimization occurred with girls who had been incestuously abused as well as with those assaulted by someone outside of the family.

Antisocial Acting Out

Children who have been sexually abused in the home situation have much to be angry about, especially if there has been a coercive element associated with the abuse and they recognize the degree to which they have been exploited. Because of their fear of the perpetrator, they are not capable of expressing their resentments directly to him. Accordingly, they may act out their anger elsewhere. If, in addition, their mothers or other potential protectors refuse to hear their complaints, the pent-up anger becomes even greater. This may be acted outside of the home, especially in school and in the neighborhood.

However, children whose parents are divorcing, especially parents who are embroiled in vicious battles, are also likely to become angry and exhibit antisocial acting out. Thus, this criterion is somewhat weakened for children of divorce. It behooves the evaluator to differentiate between anger derived from exposure to and embroilment in a parent's divorce and anger that may be the result of sexual molestation. Furthermore, there are many other causes of antisocial acting out in children, that have nothing to do with parental divorce or sex abuse. These sources of the child's anger must also be investigated before one can come to the conclusion that the antisocial behavior is a manifestation of sex abuse.

Teens who have been molested in the home situation may find the home so intolerable that they run away. This is especially the case when the youngster has not been able to obtain help and protection from the other parent (Sgroi et al., 1982).

Long-Term Effects on Adults

Numerous theoretical papers and research studies on the long-term effects of CSA have been published during the last 10-15 years. The research methodologies of these studies are as diverse as the findings. Sexual dysfunction, repeated victimization, suicide attempts, and depression are often the focus of studies on the effects of SA. Most studies do not use control or comparison groups. However, Asher (1988) looks at four studies on the long-term effects of CSA utilizing control or comparison groups (i.e., Briere, 1984; Herman, 1981; Meiselman, 1978; Tsai, Feldman-Summers, & Edgar, 1979). The results of these studies are explained in the categories below.

Sexual Dysfunction

Meiselman (1978) and Briere (1984) report that the women who had been sexually abused had a significantly higher percentage of sexual problems than the comparison groups, although Herman (1981) found no difference betwen the two groups. Tsai et al. (1979) found that victims seeking therapy had significant sexual problems but the control group of victimized women not seeking therapy did not have more sexual difficulties than the nonvictimized control group. Asher (1988) points out that sexual problems have been reported as long-term sequelae in studies not using comparison groups.

Repeated Victimization

As noted in the section on the effects of SA on adolescents, victims of SA are at risk of repeated victimization. In adults, the revictimization may take the form of increased risk of being raped or being involved in a battering relationship with a spouse or mate. Both Briere (1984) and Herman (1991) found that significantly more of the incest victims had been involved in battering relationships than had those in the control groups, but there were no significant differences between the two groups regarding rape.

Peterson and Seligman (1983) describe how the learned helplessness model might aid in understanding reactions to victimization that involved what they term "emotional numbing and maladaptive passivity" (p. 103). They propose that during traumatic episodes involving personal danger (such as incidents of SA) a response by the victim is futile. Such experiences in turn can result in learning an expectation of future helplessness, whereby the victim comes to believe that there is little he or she can do to prevent or gain control over stressful situations. The result is the development of a passive response style in new situations that may be unrelated to the one that was originally encountered. Dialogues with victims of violent crimes support this contention of learned helplessness, indicating that many victims express feelings of self-doubt, insecurity, elevated fears, and anxiety across a diversity of situations (Porter, 1986).

Suicidal Ideation or Attempts

Briere (1984) and Herman (1981) found that more incest victims than controls had a history of suicide attempts, although in Herman's study the two groups did not differ significantly. Herman reported that 60% of the incest victims exhibited major depressive symptomotology but so did 55% of the women in the comparison group. Asher (1988) notes that again, depression and suicide attempts were problems presented by victims of CSA in studies not utilizing control or comparison groups.

Dissociation

Dissociation refers to the victim's ability to temporarily remove one's psychic awareness away from reality. There is a great controversy over the reality of multiple personality disorder (MPD) in North America, despite the exponential increase in the diagnosis and treatment of MPD since 1980. Kluft (1984) provides a four-point theory for the development of multiple personality disorder: 1) patients with MPD are extremely good at dissociation and appear to have some propensity toward it, 2) patients use MPD to cope with severe childhood trauma, 3) the form and structure of MPD vary depending on the person's temperament and nonabuse experience, and 4) the abuse did not stop and the victim did not receive enough consistent love and care to heal his or her wounds.

Although MPD and other ego state disorders may be a creative and highly effective strategy for preserving the integrity of the victim in chronic catastrophic trauma, like any survival strategy gone wrong, it creates more problems than it solves. Treatment involves unlearning an overreliance on dissociation and learning more varied, flexible, and adaptive ways of coping with life.

Guilt

There are several forms of guilt. Gardner (1992) believes the child who suffered sexual abuse may well have enjoyed the experience and will not have appreciated that the behavior was something to feel guilty about. Such a child will often suffer guilt after learning that the act is an unacceptable, sinful, or even criminal act. Although caregivers may try to reassure the child that he or she was an innocent victim, they still may not be successful in assuaging such guilt. A related form of guilt that is derived from the sexual experience relates to the child having been selected from all the other children as the one for sexual involvement. The abused child gets special attention from the offender at the same time that attention is withdrawn from other siblings. Such children may consider themselves participants in activities that involved the exclusion of their beloved siblings. Hence, they feel the guilt. They may also fear a jealous reprisal by the allegedly nonfavored siblings.

Another form of guilt relates to the parents' blaming the child for initiating the sexual activities. The perpetrator will attempt to assuage his or her own guilt by blaming the child, and the child, because of cognitive immaturity, will accept the accusation as valid.

Guilt has far reaching and long-term consequences on a victim's self-esteem. Another statement by an adult survivor provides a vivid example of the hideous grip guilt holds on the adult survivor:

> I can remember being left alone in my father's car many times. He'd usually go to the bar and leave me at home, alone. I was really little the first time I remember this happening, maybe three years old. He left and I was terrified. I thought no one was going to come home and I would be left there alone forever. I cried for a long, long time. Then I got mad and took one of my crayons and began scribbling on the wall. Well, my father finally got home. He was drunk, I think. He looked at the wall, picked me up, and threw me across the room. Then he grabbed me by the hair and dragged me upstairs to his bedroom. I still had the crayon in my hand. He ripped my clothes off and took the crayon and stuck it inside me. I was screaming and crying. He kept ramming it inside of me telling me to shut up, telling me he'd teach me not to write on the walls with my fucking crayons. Something inside of me died that day....I never scribbled on the wall again. Sometimes I think it really was my fault. If I hadn't drawn on the wall, he wouldn't have had to hit me. (quoted in Sgroi, 1988, p. 117)

Sexual Abuse Syndrome?

A myriad of other symptoms have been mentioned as long-term effects of CSA. These include anxiety, phobic reactions, guilt, substance abuse, difficulty trusting both men and women resulting in poor marital and interpersonal relationships, low self-esteem, extreme passivity, and episodes of dissociation or derealization (Asher, 1988).

Briere (1984) suggests that victims of SA may develop a Post-Sexual Abuse Syndrome "consisting of symptomatic behaviors which were originally coping mechanisms or conditioned reactions to a childhood characterized by victimization" (p. 12). This syndrome develops in a similar way as other personality disorders, particularly the borderline personality (BPD). A child in an incestuous family develops maladaptive responses in order to cope with the dysfunctional family system. Once these responses are learned, they persist into adult life even when they are no longer necessary and may be viewed as inappropriate. Briere notes the similarity between diagnostic criteria for BPD and the problems experienced by women who have been incest victims (i.e., substance abuse, promiscuity, suicide attempts, self-mutilation, severe interpersonal difficulties, and episodes of dissociation).

Gelinas (1983) also supports a post-sexual abuse syndrome based on her synthesis of the literature on the long-term effects of incest. She contends that the commonly expressed sequelae constitute a chronic traumatic neurosis that emerges only after the incest has been disclosed and discussed to some extent. The symptoms such as intense expression of affect, cognitive impairment, overwhelming fear and anxiety, dissociative states, and hallucinations can be mistaken for a psychotic decompensation. Secondary elaborations such as substance abuse, chronic depression, guilt, low self-esteem, and suicidal ideation or attempts may emerge when the neurosis goes untreated. It is for these symptoms that many women seek therapy.

Whether an actual "sexual abuse syndrome" exists is quite controversial. More recently, Briere and Runtz (1990) found support for a syndrome related to maladaptive sexual behavior that is distinguishable from sequelae experienced by adult victims of either physical or emotional abuse. But, in their extensive review of the long-term effects of CSA, Beitchman et al. (1992) found that the specific effects of CSA, independent of force or threat of force or some family variables such as psychopathology, are still to be clarified. However, it is clear that adult women with a history of CSA show greater evidence of sexual disturbance or dysfunction, homosexual experiences, depression, and revictimization. As well, anxiety, fear, and suicidal ideation or suicide attempts were also found to be prevalent. The authors are cautious about labelling these phenomena as a sexual abuse syndrome, but they are optimistic about future research being driven in the direction of that hypothesis.

Gardner (1992) however, is blatantly adverse to the notion of any sexual abuse syndrome and is critical of many of the investigators who say that the child's symptoms are manifestations of the sex abuse syndrome:

> When asked what exactly is the sex abuse syndrome, they will describe the particular symptoms the child exhibits (both normal and abnormal) that are allegedly manifestations of it. There is no symptom that escapes being included in this rubic. The fact that DSM-III-R does not recognize such a syndrome and the fact that it is the only syndrome in the history of psychiatry that includes *all* psychological symptoms and behavioral manifestations-both normal and abnormal-does not deter these evaluators from resorting to this meaningless statement. I sometimes have the thought, when reading the reports of such evaluators, that DSM-III-R should have as its subtitle: "The Sex Abuse Syndrome." (p. 294)

Beitchman et al. (1992), Briere (1984), Briere and Runtz (1990), and Gelinas (1983) have examined some of the more common psychiatric sequelae of adult victims of CSA and have attempted to define a syndrome particular to CSA trauma. But, as Asher aptly states:

> Not all incest victims will fit one pattern of symptom presentation. A victim's account of abuse must not be discounted simply because she presents with symptoms not commonly thought to be associated with childhood sexual abuse. (p. 11)

Summary of Sequelae

The short-term and long-term effects of CSA commonly involve revictimization in numerous ways, all of which contribute to the long-term impact. Sexually abused children exhibit different symptoms at different age levels. Generally, young children present with behavioral symptoms that are manifestations of anxiety. As children enter latency and early adolescence, aggressive and impulsive behavior begins to appear. Older children seem to be more disturbed by sexual victimization than are younger children, perhaps because of their increased awareness of the meaning of sexual behavior. As children reach adolescence, acting out becomes more common as a way of both expressing overwhelming feelings and pleaing for help. Few sexually victimized children of any age are able to directly verbalize the distress they are experiencing.

A plethora of long-term effects of CSA appears to exist. These effects include sexual dysfunction, repeated victimization, depression and suicide attempts, anxiety and phobic reactions, guilt, substance abuse, difficulty in interpersonal relationships, poor self-esteem, and episodes of dissociation or derealization (Asher, 1988). Whether some of these sequelae can be termed as a post-sexual abuse syndrome is controversial and bears further research.

A developmental perspective of psychopathology maintains that a child forms a unique "fit" with his or her environment over time, serving both to transform that environment and to be transformed by later experiences. A child's method of adapting to environmental demands at one point in time (e.g., avoiding an abusive caregiver) may later compromise the child's ability to form relationships with others or to be more flexible in their style of adaptation. The abused child, therefore, is more prone to develop psychological disorders or adjustment problems due to the powerful influence of negative early experiences that set the course for adaptational failure.

Stroufe and Rutter (1984) propose a critical mechanism in child development entitled *adaptation failure* to account for this relationship between early childhood experiences of abuse and later disorders:

> [One] example of adaptation failure among abused children is portrayed by the child's peer relationships and interpersonal development. Early experiences of trauma, poor parental attachment, and family discord could lead the child to establish a pattern of avoidance with nonfamily members. Whereas such an adaptational style can be viewed as appropriate or understandable within the context of an abusive family, the child may have lost important opportunities for

> social support and buffers against stress and psychopathology. (p. 100)

Beitchman et al. (1992) argue that because an adult is able to assess childhood events from a different psychological perspective than the child, understanding the adult perspective is necessary to unravel the full impact of CSA. This is not to suggest that short-term effcts be minimized in favor of long-term effects since suffering and disturbance at any age call for a therapeutic response; however, a clearer understanding of the effects over time may be helpful in planning treatment and in directing the allocation of scarce resources. Although the intent is laudible, many therapeutic programs of all types are implemented without adequate research into their legitimacy. In an effort to improve assessment and treatment for victims of CSA, more research efforts could be focused on target groups of victims to determine their similarities and differences in individual response to trauma.

One example of research focusing on target groups is the differences between male and female victims of CSA. Porter (1986) states that two issues surface repeatedly among males that differ markedly from issues of female victims. The first is the confusion of sexual identity arising from early sexual abuse. The second involves feelings of powerlessness demonstrated by later aggressive sexual behaviors, known as victim/offender patterns: "Countering societal homophobia and repudiation of the boy as victim...are crucial educational components in male-victim treatment and recovery" (p.13).

Although many of the sequelae thought to be associated with CSA have been identified in this review of sequelae, it is difficult to determine an individual's reponse to trauma and, therefore, one is advised to take precaution and avoid the term *sexual abuse syndome.* As Wolfe (1987) states: "Overall, the nonspecific signs and symptoms of developmental deviation or peculiarity appear to be indicative of the child's trauma rather than the presence of a recognizable pattern of symptoms per se" (p. 121). Future research on the differential impact of CSA should more closely examine characteristics of the victims as well as factors directly related to the abuse.

Chapter Two
(Part Five)

Controversy Over Professional Response to CSA

Current Issues in the CSA Phenomenon

The sexual abuse of children is currently receiving the type of attention in both the popular press and professional journals that rape, child abuse, and spousal assault received 10 to 15 years ago: "Many of the same controversies that surrounded these other issues, including the veracity of the reports, the extent of the negative efffects, and who is to be held accountable for these acts, are now being debated with regard to the sexual abuse of children (Asher, 1988, p.3). Unfortunately, it is difficult to obtain a balanced review of some of the issues due to the extreme polarity in much of the popular and professional literature:

> At this point both professional and laypersons place themselves in one of two camps. One group believes that the vast majority of sex abuse accusations are true, regardless of the situation in which they arise. Another group holds that the mass-hysteria element is so widespread that most (if not all) of the accusations are false. It comes as a surprise to me that most individuals have difficulty accepting the reality that one can have *two* epidemics coexisting, namely, an epidemic of sex-abuse hysteria surrounding true accusations, and a separate epidemic of sex-abuse hysteria related to false accusations. (Gardner, 1992, p. xxxviii)

Currently, there are major CSA issues raging in the media that have to do with CSA and satanic ritual abuse, CSA and memory recall, and CSA and false allegations in custody disputes and daycare or playschool settings. Much of the controversy comes from the adult perspective which Beitchman et al. (1992) advocate is beneficial if we are to attempt to understand better methods of treatment for current child victims. These issues are addressed in the following sequence: a discussion of the satanic ritual abuse (SRA) syndrome; the reliability of reports on CSA with and without SRA; accountability of professionals in clinical practice; and requirements of victims in the adversarial justice process.

Satanic Ritual Child Sexual Abuse

Various terms are used to describe situations in which satanic or ritual abuse allegedly occurs in conjunction with the sexual abuse of children. Finkelhor, Williams, and Burns (1988) define ritualistic abuse as "abuse that occurs in the context linked to some symbols or group activities that have a religious, magical, or supernatural connotation, and where the invocation of these symbols or activities are repeated over time and used to frighten and intimidate children" (p. 75).

There are misunderstandings over terms. Ritualistic abuse and satanic abuse are often used synonymously, and yet clearly there can be rituals integral to child sexual abuse but without satanism:

> One of the basic problems of discussing or publishing articles about "ritualistic" abuse of children is how to precisely define it. After eight years of trying I have given up and prefer not to use the term. It is confusing, misleading, and counterproductive. The use of the word satanic is almost as confusing and certainly more emotional. I prefer the term multidimensional child sex ring.
>
> Not all ritualistic activity is spiritually motivated. Not all spiritually motivated ritualistic activity is satanic. In fact, most spiritually or religiously based abuse of children has nothing to do with satanism. Most child abuse that could be termed "ritualistic" by various definitions is more likely to be physical and psychological than sexual in nature. Not all ritualistic activity with a child is abuse or a crime. (Lanning, 1991, p. 171)

Furthermore, Putnam (1991) distinguishes among child and adult accounts of satanic ritual abuse (SRA):

> It is commonly asserted in SRA trainings that the allegations of adult and children SRA victims are very similar, supporting claims that satanic cults are multigenerational. In actual fact, there are often major discrepancies between adult and child descriptions of SRA activities suggesting that these two sets of allegations may derive, in part, from separate sources and that they are not simply transgressional equivalents....teenage use of satanic symbols and themes in heavy/punk metal rock music and culture is not directly related to the SRA allegations made by children and adults. (p. 176)

Common Themes Cited in Accounts by Victims of Transgenerational SRA

There are two different perspectives on transgenerational SRA and child sexual abuse. The first comes from adults who allege they experienced this type of abuse in childhood. The second is related to children making current allegations in residential or daycare settings.

After some years of working with sexually abused children and their families, practitioners encounter children who have been subjected to sadistic, perverse, and sometimes bizarre practices. Some of these acts approach the very reaches of human imagination, so professionals may find it extremely difficult to maintain neutrality when faced with such histories.

Commonalities exist in the descriptions from children and adults recalling childhood experiences of SRA. Two recent studies which are cited frequently are Jonker and Jonker-Bakker (1991), who studied child victims in a daycare setting in the Netherlands, and Young, Sachs, Braun, and Watkins (1991), who studied American adults alleging to be victims of SRA from childhood. Jones (1991) sums up the common themes found in the accounts of adult survivors and children:

> Both sources have described perverse sexuality with sadistic elements such as the passage of sticks or objects into vagina, anus, or penis. Children have reported being silenced by extreme physical violence and threats accompanying the sexual violence. Subsequently, the children have become terrified to tell anyone because of guilt, shame, and secrecy. Very often the children were young when first initiated into these activities, and later on sex between children was encouraged by the abusers, which seems to have had the effect of deepening the children's guilt and restricting opportunities for disclosure. Children described the sexualization of defecation and urination and allege that they were given drugs and/or alcohol before and during such activities. Some children have described that either they or their abusers dress up with masks, robes, and other unusual clothes. If the abuse involved more than one child, parties and group games may have been used to initiate new recruits, lowering their resistance to becoming involved in worse activities. Sometimes pornography was a prominent feature, seemingly both for its own sake and to lower children's resistance by normalizing the activities. Finally, in some instances all these elements are sometimes coordinated into a satanic ritual and belief system in which the children allegedly participated and were misused sexually and physically as an integral part of the religion....Descriptions given by children include being tortured or witnessing sacrifice of animals and humans, the consumption of bodily parts and fluids, and burial ceremonies. (p. 163)

A Satanic Ritual Abuse Clinical Syndrome?

Reports of abuse in connection with satanic rituals have been included in descriptions of the types of childhood abuses reported by multiple personalities (Braun, 1986; Kluft, 1988; Putnam, 1989). Other authors have described ritual abuse and some of the consequences for adult and child survivors. (Gould, 1987; Kelley, 1988; Terr, 1988). Hill and Goodwin (1989) noted the similarities between current patient reports and historical descriptions of 11 satanic rituals. Young et al. (1991) studied 37 adult cases with similar psychopathology who report having been abused in childhood during the rituals of satanic cults. In this study satanic cults were specifically defined and limited to intrafamilial transgenerational groups that engage in explicit satanic worship which include the following criminal practices: ritual torture, sacrificial murder, deviant sexual activity, and ceremonial cannibalism.

Thirty-seven patients (33 female, four male), ranging in age from 18-47 years, were evaluated over a period of 2 years (1986-1988) following referral for treatment of dissociative disorders. Thirty of the 37 adults were treated as inpatients and seven were outpatients. Although the inpatients attended some group activities and had opportunities for informal interaction, the authors believe that there was minimal discussion between patients of their reports of satanic abuse, as patients tended to be secretive and reluctant to share information:

> Most of the information and reports of childhood ritual abuse emerged gradually over the course of treatment. Patients typically presented with some memories of abuse at home, but nearly complete dissociation for the ritual abuse. At times, intrusive images of cult abuse arose unexpectedly while patients were in the process of working through memories of familial abuse. Reports occurred spontaneoulsy as patients abreacted, dreamed, or experienced flashbacks of people wearing robes in rituals. Reports also occurred in dissociated states and during hypnotic interviews. In general, those related during dissociated states, hypnosis and abreactions appeared in piecemeal fashion. They often appeared to be a combination of a number of memories that had been condensed and lacked a clear sequencing of events. The reports were elaborated as treatment progressed and patients could focus in greater detail on material that was deeply repressed. Additional information was obtained from patient journals, artwork and, in a few cases, through a review of clinical

> records suubsequent to discharge from the treatment facility. (p. 183)

Young et al. (1991) determined a clinical syndrome based on the presentation of the 37 subjects. The top eight psychiatric sequelae from reported ritual abuse in childhood include severe post-traumatic stress disorder (PTSD), dissociative states with satanic overtones, survivor guilt, indoctrinated beliefs, unusual fears, sexualization of sadistic impulses, bizarre self-abuse, and substance abuse.

Assessment and Evaluation of Allegations of Satanic Ritual Abuse

In a 1993 study by Shapiro-Gonzalez, Waterman, Kelly, McCord, and Oliverti, 63 children reported SRA in an American preschool setting. The investigators studied the patterns of disclosures and recantations of SRA allegations while the children were in psychotherapy. They conclude that disclosure is a continous process as children oscilate between disclosures and recantations. They also found evidence that the children's experience within the legal system may be associated with recantations. Children tend to make vague disclosures before revealing more specific acts, reveal less intrusive sexual abuse (e.g., kissing) before more intrusive types (e.g., intercourse), and to disclose ritualistic abuse after other types.

There are many valid perspectives from which to assess and evaluate allegations of child sexual abuse. Lanning (1991) presents an insightful commentary on commonly held perspectives by parents of the victim, therapists, child welfare workers, and law enforcement:

> Parents may choose to believe simply because their children make the claims. The level of proof necessary may be minimal because the consequences of believing are within the family.
>
> A therapist may choose to believe simply because his/her professional assessment is that the patient believes the victimization and describes it so vividly. The level of proof

> necessary may be no more than therapeutic evaluation because the consequences are between therapist and patient. No independent corroboration may be required.
>
> A social worker must have more real, tangible evidence of abuse in order to take protective action and initiate legal proceedings. The level of proof necessary must be higher because the consequences (denial of visitation, foster care) are greater.
>
> The law enforcement officer deals with the criminal justice system. The levels of proof necessary are reasonable suspicion, probable cause, and beyond a reasonable doubt, because the consequences (criminal investigation, search and seizure, arrest, incarceration) are so great. The level of proof for taking action on allegations of crimminal acts must be more than simply that someone alleged it and it is possible. This in no way denies the validity and importance of the parental, therapeutic, social welfare, or any other perspective of these allegations.
>
> When, however, therapists and other professionals begin to conduct training, publish articles, and communicate through the media, the consequences become greater, and therefore the level of proof must be greater. (p. 172)

Reliability of Reports From SRA Victims

The Search for Legal Evidence of Satanic Ritual Abuse

Law enforcement has the obvious problem of attempting to determine what actually happened for criminal justice purposes. Therapists might also be interested in what really happened in order to properly evaluate and treat their patients. How and when to confront patients with skeptism is a difficult and sensitive problem for therapists. Lanning (1991) states:

> Until hard evidence is obtained and corroborated, the public should not be frightened into believing that babies are being bred and eaten, that 50,000 missing children are being

> murdered in human sacrifices, or that satanists are taking over America's daycare centers. No one can prove with absolute certainty that such activity has NOT occurred. The burden of proof, however, as it would be in a criminal prosecution, is on those who claim that it has occurred, only goes so far in explaining the lack of evidence. (p. 173)

Lanning is an American police detective who began to hear victim's stories of bizarre cults and human sacrifice in the early 1980s. But, he says, accounts continue to grow and grow: "We now have hundreds of victims alleging that thousands of offenders are murdering tens of thousands of people, and there is little or no corroborative evidence" (p. 172).

Putnam (1991) also remarks that despite the widespread dissemination of information on alleged SRA activities and the increasingly frequent diagnosis of SRA in patients with dissociative disorders, there is a complete absence of independent evidence corroborating the exstence of such cults or their alleged activities such as human sacrifice, cannibalism, and sex and death orgies. Similarly, the police in Holland and England, despite intensive investigations, have failed to find any evidence substantiating allegations of SRA.

For the last decade American law enforcement has been aggressively investigating the allegations of victims of ritualistic abuse. There is little or no evidence for the portion of their allegations that deals with large-scale baby breeding, human sacrifice, and organized satanic conspiracies. Putnam (1991) states that the picture of the alleged satanic cults that emerges from the two papers (Jonker & Jonker-Bakker, 1991; Young et al., 1991) is not readily believable:

> On the one hand, they are said to be highly organized, multigenerational, international groups with membership turnover....On the other hand they are depicted as evil incarnate participating in violent cannibal rape orgies, which incredibly leave absolutely no trace of the blood and gore spilled. Equally

> incredibly, in the case of the Jonker and Jonker-Bakker paper, they were able to repeatedly lure large numbers of children away from their normal school or play activities, drug them, and force them to participate in painful and disgusting rituals without anyone ever noticing that the children were missing or without the children protesting to their parents or teachers. Such total child crowd control is incomprehensible to anyone who has ever tried to herd a group of children through a museum or zoo.
>
> One must ask how can such large scale, violent, and bloody activities escape detection in every single instance where they have been alleged to have occurred? (p. 178)

Lanning (1991) says that it is now up to mental health professionals, not law enforcement to explain why victims are alleging things that do not seem to be true: "Mental health professionals must begin to accept the possibility that some of what these victims are alleging just did not happen and that this area desperately needs study and research by rational, objective social scientists" (p 173).

Credibility of SRA Reports by Victims and Counsellors

Jones (1991) provides a lively synopsis of assessing the credibility of victims' accounts of SRA. He notes that potentially there are the following sources of evidence: the children who allege they have been abused; those adults who claim they were abused as children; abusers' admissions, third-party witnesses; and finally, crime scene investigations. At present most data is coming from the memories of adults abused as children and from children themselves. We have heard much less from the police whose crime scene investigations have in large part drawn a blank. Jones expresses the logical dilemma one faces: "How could children fantasize or lie about something so graphic and terrible? On the other hand, where are the bodies or evidence of blood and sacrifice?" (p. 166).

If the source of allegations are children's recent memories or adult memories of childhood, Jones further reasons three explanations seem possible when assessing the credibility of an allegation: (1) that the events occurred exactly as described; (2) that the events described did not actually happen, and children or adults are mistaken or telling lies; and (3) that some events occurred but other aspects are fictitious.

The first option has already been considered and met the obstacle of the absence of police scene verification. Corroborative evidence presented in the Young et al. (1991) study is considered too "soft" for court evidence. The authors state the difficulty in securing evidence:

> Confirmatory data and hard evidence in support of the patient reports was difficult to secure. None of these cases were referred to law enforcement agencies for verification. Family members were not contacted for reasons of confidentiality and because patients typically reported the involvement of at least one family member in the satanic worship. The patients expressed fears of retaliation if cult members should learn that they were reporting cult activities. (p. 186)

The physical examinations of the patients in this study revealed a number of stigmata: a distorted nipple and a breast scar from alleged rituals, scars on the back that were not likely self-inflicted, a satanic tatoo on a man's scalp of a specific cult, cases of endometriosis and pelvic inflammatory disease prior to age 15. Corroborative evidence was also obtained when patient photographs of alleged cult members were shown to other patients from a similar geographic region. Four patients independently identified, by name and cult roles, the individuals in the photographs. Neither group of patients were in contact with each other during their treatment with the authors when these independent identifications were made.

Contamination of Reports of Child Sexual Abuse

The second possibility for SRA phenomenon is that the events are entirely factitious. The mechanisms put forward are those of mass hysteria, contamination from one source to another, leading interview practices by over zealous practitioners, child fantasies fed by video films containing occult and horror scenes. We do not have convincing evidence that such mechanisms can explain all the allegations made, or that a once fictitious account has been created in such a way it can be held with conviction, often for years, and accompanied by manifest distress. Kelly (1988) gives an account of the effects on children, and Briere (1988) reports evidence of more serious psychological impact on adults abused in childhood in bizarre or perverse ways than for other SA.

True and False Allegations of SA by Children

Although it is generally accepted that the majority of children do not lie about SA, there are some factors that may predispose a false allegation of SA. One of the most common factors is an ongoing custody battle. Whereas Jones and McGraw (1987b) report a false allegation rate of 7%, it has been suggested that in cases involving disputed divorce, custody, and visitation issues rates of false allegations may be as high as 50% (Raskin & Yuille, 1989). Other factors that may also lead to a false allegation are the expression of anger towards a parent or the psychiatric illness of a parent may initiate the allegation.

The *parental alienation syndrome* (Gardner, 1987) is a disorder that arises in child custody disputes in which a child will view one parent as all good and another as all bad. Gardner explains:

> Most often the mother, who has been the primary child rearer, is viewed as perfect or close to it, and the father, who is disputing for custody, is viewed as a despicable individual. Such children guiltlessly vilify the father and create a variety of malevolent delusions about him. Most often these children have been programmed by their mothers to hate their fathers, but the children themselves often contribute their own scenarios of hostility. It is this *combination* of both the parent's and the child's contributions that warrant this term. (p. 160)

Blush and Ross (1987) coined the term *Sex Abuse in Divorce Syndrome* (SAID) to represent the constellation of behavioral manifestations in which a child fabricates sex abuse in the context of a divorce dispute. They describe such children as enjoying significant power in that they are primary vehicles in which the accuser communicates with the accused, and their accusations can literally destroy and/or remove the accused.

Gardner claims that false accusers may have created a litany for the benefit of the parade of examiners who interview them. This has a rehearsal quality and may include adult terminology. At a moment's notice, they are ready to "turn on the record" and provide a command performance. This indicator is especially applicable to the term *programming,* which is frequently used when referring to the process by which a child develops parental alienation syndrome. It is as if the brainwashing process imbeds in the child's brain a scenario that can be reproduced when the proper button is pushed.

But, there are also reasons why legitimate issues of CSA may arise in marriage breakdown. On the one hand, Gardner says that children who have been genuinely abused are not creating any stories. They are telling the truth about an actual experience. Their renditions have the quality of credibility rather than a rote repetition of a well-rehearsed scenario.

On the other hand, Gardner claims there are hundreds of cases where over zealous advocates of children's rights inadvertently promote and program false accusations of CSA in their investigation such as leading questions in repeated interviews. This is especially the case in custody disputes as well as in cases over alleged SRA in daycares. He says that one differentiating criteria to note is that children who have been genuinely abused describe well the details of their abuse and generally confine sexual discussion to these specific experiences. Those who are providing false accusations, having no such experiences, create their scenarios. Originally, the basic elements and guidelines are provided by the programmer, although he or she will claim that the comments flowed initially from the child without any prompting or coaching. However, additional elements are inevitably brought in the scenario. These are encouraged both by the original programmer and other interrogators, especially "validators." These additional elements may be derived from classroom sex abuse prevention programs, videotapes, audiotapes, coloring books about sex abuse, or pornographic movies observed by the child without the parent's awareness. Examiners do well to inquire into the child's experiences with such exposures. There was a time when nursery school was an innocent environment in which the only sexual issues to which the child was exposed were related to bathroom functions, but this is no longer the case. As Lanning (1992) states:

> The odds are fairly high that in any typical day-care center there might be some children who are victims of incest; victims of physical abuse; victims of psychological abuse; children of cult members (even satanists); children of parents obsessed with victimization; children of parents obsessed with the evils of satanism; children without conscience; children with a teenage brother or pregnant mother; children with heavy metal music and literature in the home; children with bizarre toys, games, comics, and magazines; children with a VCR and slasher films in their home; children with access to dial-a-porn, party lines, or pornography; or children victimized by a daycare center staff member. The possible effects of the interaction of such children prior to the disclosure of the alleged abuse must be evaluated. (p. 26)

In response to what many victims and therapists feel is revictimization by nonbelievers, there is growing research into the field regarding possible antecedent factors and typical patterns involved in this phenomena. Many professionals, theorists, and laypersons strive on in the hope of discovering some sort of meaning to the increasing number of alleged victims, despite the frustration in recognizing the almost nonexistence of "hard" evidence for such an occurrence. Several researchers attempt to explain the phenomena (e.g., Kent, 1993a, 1993b) or outline typical symptoms one can expect to observe (e.g., Edwards, 1990). Treatment issues are focused mainly around the controversial diagnosis of MPD or the neutralization of cult mind-control programming. Putnam (1989), a well-known researcher in this field, writes that although reliable estimates are not available, it appears that a significant subgroup of MPD clients were subjected in childhood to ritualistic abuse by cult members.

False Memory Syndrome Debate

Heuristic research theories on how memories may be perceived, stored, and recalled are either too complicated or of too little interest for most counsellors and adult survivors. Instead, many turn to more practical considerations such as personal accounts by victims and self-help books such as The Courage to Heal by Bass and Davis (1988). Critics revel in quotes such as, "If you don't remember your abuse, you are not alone. Many women don't have memories, and some never get memories. This doesn't mean they weren't abused" (p. 81). Gardner (1992) makes a cryptic statement:

> With so many "therapists" per square inch, it is not surprising that there is significant competition for patients....There are probably more sexually abused patients seeking treatment today than ever before in the history of psychiatry. Accordingly, sex abuse "experts" are sprouting up in every field, coming out from every stone, and suddenly appearing from behind every tree....Some of these therapists are so frantic that they will treat patients for nothing, so noble do they consider their cause....These are the people who are ever waving the banner "children never lie" and are deeply committed to the dictum that if a child claims he or she was sexually abused, it must have happened. The extension of this is that "adult women never lie." (p. 64)

It is in response to the growing denial of parents who claim to have been falsely accused by their adult daughters of CSA that the False Memory Syndrome Foundation (FMSF) was established in Philadelphia. According to Pamela Freyd, the Foundation's Executive

Director, there is a common pattern to these allegations. The pattern is as follows: an adult (female) goes to therapy for assorted reasons; therapist suggests sex abuse occurred; client says she doesn't think so; therapist encourages her to read The Courage to Heal , analyze her dreams, undergo hypnosis or guided imagery, attend self-help groups; client begins to remember abuse and is encouraged to confront her family. If the abuse is denied, she cuts herself off from her family, often preventing her parents from seeing their grandchildren as well. Parents have no way to prove their innocence.

The profiles of these families are also interesting. According to the FMSF, 80% of accusations are made by daughters 25 to 45 years old; 90% of the charges stem from so-called “recovered’ memories; 17% of these families are being sued in the United States by their grown children; 15% of the accusations involve satanic ritual abuse (SRA); the majority of the siblings do not believe the accusations; more than 80% of parents are still married to the same spouse; the median income of parents is more than $60,000; and 60% of parents completed college, with 25% having advanced degrees.

The FMSF is growing at a phenomenal rate, and is developing a high profile in the media. As of May, 1993, it boasts 5,000 families as members. While there are always those who conduct themselves in less than a professional manner, many therapists who work in difficult emotional situations with survivors feel that their credibility and legitimate therapeutic process is being undermined by the FMSF and the media.

Attempting a Balanced Perpective

The third possibility in assessing the credibility of SRA abuse accounts is that some events actually occurred and others are fictitious. Now there are additional problems related to patient reliability.

It is striking that the subjects in the study by Young et al. (1991) report many similar experiences despite coming from diverse areas, being treated in different locations, and having minimal contact with each other. However, the authors do not rule out the possibility that the patients have read nonprofessional literature describing reports of satanic cult activity and ritual childhood abuse. They could have incorporated certain incidents from articles or books as "pseudomemories," and retrieved them with the same conviction as real memories (American Medical Association, 1985). It is also possible that these patients have developed a powerful satanic metaphor for conveying and explaining other forms of severe abuse actually suffered during their childhoods (Young et al., 1991).

If we asume that some sexually traumatic events have occurred in association with SRA, there are a number of explanations why memories may be questioned: (1) Psychological abuse, integral to satanic practices with threats of separation and to personal safety, may be so overwhelming as to distort the child's memory; (2) Patients often report being drugged during rituals which could affect the ability of their recall; and (3) Recall could also be influenced by deceptive cult practices designed to confuse initiates.

Patients have reported that as older children they assisted in the deception of younger children (e.g., switched dolls for real infants); "If patients were very young at the time of abuse, the reports would contain distortions related to the stressful circumstances in which the memory was encoded and reflect their immature cognitive capacities" (p. 185).

A fourth reason the reliability of victims' accounts are questioned is that various internal misperceptions may also occur in dissociated states. Young et al. report that one patient dissociated into a personality state who cut a pentagram on her forearm and marked her room with cult symbols. Later she had no idea what had happened, but another dissociated personality described a cult member who marked the wall and then cut her. This was experienced as a real external event by the second dissociated personality, who was unable to recognize that an internal interaction between dissociated states had been mistaken for a real event. On the other hand, the development of dissociative identity disorder (DID) is known to follow prolonged abuse in childhood and that a large percentage of abused children will use dissociative defenses in childhood (Kluft, 1985; Putnam, 1989; Spiegel, 1986). Therefore, it is not surprising that if patients endured extensive and terrifying SRA in childhood, they would subsequently appear in clinical treatment settings presenting dissociative defenses.

Another reason memories of SRA in childhood are questioned has to do with methodology. The reliability of memories retrieved during hypnosis has been the subject of exhaustive study (Pettinati, 1988). While hypnosis has been found to enhance recall of repressed memories in amnesic patients, it may also result in the reporting of increased amounts of false information (American Medical Association, 1985). Young et al. (1991) report that the patients in their study who integrated personality states during treatment became increasingly certain that their reports of ritual abuse reflected actual memories. The patients who remain fragmented were less inclined to be certain about what really happened. The patients often had difficulty reporting memories separately and sequentially, similar to the tendency of deeply hypnotized subjects to recall memories in a disconnected fashion:

> Unfortunately, a definitive statement about the authenticity of memories retrieved during hypnosis cannot presently be made, other than to note that memory may be both enhanced or fabricated during hypnosis. Only the independent verification of patient reports can absolutely determine their credibility. (p. 186)

Accountability in Clinical Research and Practice

Lanning (1991) says that some of what victims of ritualistic abuse allege is physically impossible (victim cut up and put back together, severe injuries with no scars); some is possible but improbable (human sacrifice, cannibalism, vampirism); some is possible and probable (child pornography, clever manipulation of victims); and some is corroborated (medical evidence of vaginal or anal trauma, offender confessions). What causes Lanning's dismay is that the principal criteria for many professionals' acceptance of these allegations by victims is simple: Is it possible? "If what the victim describes is impossible, they look for alternative explanations (e.g., misperceptions, offender trickery, or symbolic meaning). If what the victim describes is possible, they accept it" (p. 173).

Putnam (1991) is also skeptical of the incredulity of victims' accounts and of the increasing numbers. He suggests much of what we know is a type of propaganda:

> Although a few articles alleging SRA activities have been published in clinical journals, most of the information now circulating in the therapist, child protective service, and police communities is derived from workshops, seminars, symposia, and lectures delivered at trainings and professional meetings....Most SRA workshops proceed from the strongly held conviction that SRA activities are real and constitute a major threat to our society. (p. 175)

Putnam also criticizes both papers of Jonker and Jonker-Bakker (1991) and Young et al. (1991) for attempting to determine a unique SRA syndrome when neither study used a comparison group. (This could be accomplished by comparing adult MPD patients who did not report SRA or comparing children who were going through different types of stress and trauma.) Furthermore, Putnam (1991) questions Jonker and Jonker-Bakker's paper for eroding the image of the police by repeatedly stating or implying, without specifying any actual evidence, that the police were, at best, incompetent, unqualified, and neglectful:

> In the future, reviewers must require higher standards of data collection, documentation, and analysis to support claims of SRA syndrome specificity....Unsubstantiated charges of police or government incompetence or neglect in the handling of SRA investigations should not be published in professional journals as they only serve to erode public and professional trust in the law enforcement community. (p. 176).

Just as the CSA research field has its problems, there are difficulties unique to the practical field as well. It is challenging for clinicians to determine a middle ground in the assessment and treatment of victims alleging SRA. Lanning (1991) expresses his regret that many experts seem unwilling to even consider the possibility that *some* of what the victims describe may not have happened. He suggests a middle ground that is a continuum of possible activity: "Some of what the victims allege may be true and accurate, some may be misperceived or distorted, some may be symbolic, and some may be 'contaminated' or false. The problem, however, is to determine which is which" (p. 173). Putnam (1991) notes how the beliefs of authors often express a firm and unwavering conviction that events did in fact happen and were accurately described by the children:

> Sandra Butler shocked the professional world with her book Conspiracy of Silence. In it she states clearly what every abused child had known for centuries, that all who try to tell are commanded to silence one way or the other, and that those people who dare to help the victims to tell are treated similarily. The more savage and perverse the crime, the more pressure to keep the secret. Brownmiller (1975) made comments about power and sex and history. Simply put, the abuse had all been going on for years. As we unearth the crimes to women and children over the past twenty years, we now are seeing the last crime of all...ritual assault. (Edwards, 1990, p. 68).

The reports to date emphasize the need for care with regard to interviewing the children when such allegations arise. In many respects good practice is simply rendered more poignant with the need for nonleading questioning, careful recording of the full interview process including its preparatory stages, and the requirement upon interviewers to suspend judgment of the exact meaning of a child's account until all possibilities are weighed. In addition where satanism is suspected, even closer supervision of interview work could improve the maintenance of neutrality, as could the use of different interviewers if the case is a multiple one. Professionals also need information, back-up, and emotional support to preserve objectivity.

Contamination between parents and between children is a vital factor if there are multiple victims. Informing the parents and providing adequate emotional support to them from the early stages of investigation may lesson the tendency to contamination. Parents need clear information and authorative instructions if they are to be helped to avoid forming their own network of parallel "investigation." This understandable tendency seems to have been an important factor in some of the cases that have ended in confusion and subsequent disrepute.

Allegations of SRA by children or adults highlight the difficulties of multidisciplinary teamwork. A painstakingly detailed record of the exact sequence of events will be necessary in order to assess credibility:

> If the guilty are to be successfully prosecuted, if the innocent are to be exonerated, and if the victims are to be protected and treated, better methods to evaluate and explain allegations of ritualistic "child abuse" must be developed or identified. Until this is done, the controversy will continue to cast a shadow over and fuel the backlash against the validity and reality of child sexual abuse. (Lanning, 1991, p. 173)

Summary

While there may not be sufficient evidence for a unique SRA clinical syndrome as Jonker and Jonker-Bakker (1991) and Young et al. (1991) indicate, Jones (1991) suggests clinicians have three fundamental concerns in assessment and treatment of this type of patient/client: (1) The embedding of CSA within a powerful belief system, especially deviant ones such as satanism, creates significant and long-lasting distortion of the victim's attitudes, beliefs, allegiances, and fundamental personality structure to such a degree that adaptive recovery is very difficult. (2) The combination of CSA with premediated and sadistic activities appears to result in more serious psychological effects. (3) CSA accompanied by extreme degradation and demeaning the victim seems to have devastating consequences for the victim's self-esteem.

Work by Briere (1988) lends support for these clinical concerns. However, all these areas of concern emphasize the extent to which CSA is accompanied by emotional or physical abuse: "It may be more helpful to think in terms of the extent to which psychological or physical abuse co-exist with sexual abuse in the individual case" (Jones, 1991, p. 164).

Hysterical contamination between parents and/or professionals in this highly emotive area has parallels in other situations and therefore has to be guarded against in investigating multiple CSA cases involving bizarre abuse. In outbreaks of mass sociogenic illness the role of the media is an important one in fanning the flames of hysteria. The quality of professional interviews varies and leading questions create added problems in cases involving multiple victims.

At present each explanation must be considered feasible. Some allegations of SRA are possibly genuine despite lack of evidence, others largely or entirely factitious, and a third group true but with a large overlap of confused and muddled added memories, in addition to genuine CSA. The most likely explanations for the majority of cases seem to be the second and third possibilities, in view of the known confusing effects of the following factors: severe traumatic events themselves, strange rituals, hypnosis, drugs, alcohol, mass hysteria, and suggestive interviewing practices. However, crime scene verification may be forthcoming to confirm satanic rituals involving children. It is most improbable that one of these mechanisms explains all cases and currently each seems a possibility until we have more information.

The Adversarial Justice Process: Disclosure and Credibility of Witness

Disclosure

Guilt and Fear

Children who have been genuinely abused are often quite hesitant to reveal the abuse. They may feel guilt or shame about their participation in the sexual acts. Or they may have been threatened with dire consequences if they divulge the abuse. They are fearful of inquiries by professionals and often have vowed to keep the "special secret" about "our little game." Such fear may relate to the threat of the abuser that terrible harm will befall them and their loved ones if they are ever to reveal the sexual activities. Some abused children have been beaten as a warning of what will happen to them if they divulge the secret. Some children are bribed with material goods and money in order to discourage divulgence. Accordingly, it is unlikely they will focuss the abuse spontaneously. Even when the examiner brings it up peripherally, they may avoid the subject. Some abused children will directly state that they don't wish to talk about their experiences with the accused. For these children, a few interviews may be necessary before the examiner will be able to obtain direct information relating to the abuse.

Older children who have been genuinely abused are likely to feel guilt over the divulgence of sex abuse because of the appreciation of the terrible consequences to the perpetrator. The younger the abused child, the less the capacity to experience such guilt. Assessing a child's guilt may be very difficult, especially because there are obviously no objective ways of evaluating it. There are no specific facial expressions, gestures, or vocal intonations that are exclusively manifestations of guilt. Often, it is only after a detailed exploration of the child's thoughts and feelings about the alleged perpetrator that the examiner will be in a position to determine whether guilt is present and whether it relates to the alleged perpetrator.

Many child sex abusers are very domineering individuals whose whole families are subjugated by them. This may have contributed to a situation in which the perpetrator was allowed to subject the child to sexual abuse. The sexual abuse is just one example of the general emotional and even physical abuse to which the family is subjected. Some families are tightly knit units in which the abusing father dominates the family and does everything possible to remove the family members from social involvement. This may serve the purpose of reducing the likelihood of divulgence of the abuse and also may lessen the likelihood that others may similarly gain gratifications from the abused family members.

Most often, mothers of children who are abused are very reluctant to admit the abuse, and they may go for weeks, months, and years denying it, both to themselves and to others. Some are passive-dependent types who are fearful of divulging the abuse lest they be beaten or otherwise subjugated or penalized by their husbands. Others may recognize that disclosure of the sex abuse may destroy the family and even bring about the incarceration of the accused. They would rather live in a situation in which their children are being sexually abused than suffer the break-up of the marriage and the attendant effects on the whole family. There may be a long time-lag between the first disclosure(s) and the bringing of the abuse to the attention of others.

Professional Attitudes

Another factor in considering problems with discloure or discovery is that of professional attitudes. In their interviews with adult women who had been sexually abused as children, the Women's Research Centre in Vancouver (1989) learned that many survivors see school as the only realistic intervention point for young victims. The authors state:

> Because all children are required to attend school, it is also a potential detection and intervention point for children who are being sexually abused at home. School is the one place where a child regularly comes into contact with adult authorities who

> have power in relation to her life and within the community. It is a place, too, where adults can reach children with the kind of discussions which might encourage their disclosure of sexual abuse....Society is beginning to recognize the prevalence of sexual abuse, the plight of the children who are being sexually abused, and the damage caused by sexual abuse. (p. 70)

A decade ago, Milgram (1984) stated that as a result of the recent publicity given problems of child abuse society now expects teachers to be fully informed, to educate both children and parents, and to actively intercede in abuse cases. Recently, Berliner (1991a) reiterates this view:

> Child abuse reporting laws unquestionably provide protection for abused children and have led to the rehabilitation of many abusive parents and the reconstruction of dysfunctional families. It would be unconscionable to return to the days when parents were free to treat their children any way they wished or to commit crimes upon them with impunity. For environments is antithetical to fundamental professional values. (p. 111)

Unfortunately, there is evidence to show that teachers may not be responding in the most appropriate manner, if at all. In a revealing study of 440 teachers' awareness of child abuse and neglect, McIntyre (1987) found three pervading themes: 1) most teachers believed they had never had an abused or neglected child in their class; 2) most indicated that they would recognize signs of physical abuse but not sexual abuse; and 3) most said that while they knew their responsibilities to report suspected abuse under law, few would report it if parents or a principal objected.

In addition to not receiving sufficient training in the recognition of signs and symptoms of sexual abuse, there are probably numerous other reasons for the lack of response from schools. There are those educators who feel that they are there to teach, not to be social workers. Berliner (1991b) talks about the "collective denial" of the reality of victims' pain. By choosing to ignore or disbelieve that childhood abuse is prevalent, professionals are shielded from the horrors they do not wish to face. This is the same phenomenon discussed earlier about the denial of SRA.

Another possibility is that teachers and daycare workers are frightened to report their suspicions of child maltreatment and then find out later that the child made a false allegation or that the allegation cannot be proven. Many worry about the backlash from higher authorities or the child's parents should they not be "right" about the abuse. Most seem unaware that they have a legal obligation to report all suspicions of abuse to child protective agencies to underline consensual abhorrence of child abuse, to send a message that potential abuse is under scrutiny, and to bring to bear societal resources to prevent and treat it.

A fourth reason child care and school professionals may fail to respond to sexual abuse is that "believing is seeing." Pervading misconceptions about who gets abused and who does the abusing may hinder one's perception of what is happening to a child. For instance, if an abused child comes from a well-to-do family with parents who are upstanding in the community, a teacher may fail to even consider the possibility of intrafamilial abuse, especially if that teacher also believes in the myth that sexual abuse only occurs in the lower socioeconomic strata of the community.

Further evidence of the need for teachers and other professionals who are in daily contact with children to recognize their misconceptions comes from a study by Peterson and Franzese (1987). They found a positive relationship between the tendency to abuse and the acceptance of rape myths, downplaying sexual asault as a problem, and rather traditional views of women's role in society. Some of these myths are that women enjoy being raped, and victims provoke rape by acting seductively. These individuals tend to blame the victim and not the rapist. If we think that these men are extremely disturbed and a rare breed not to be easily found among potential professionals, a study by Malamuth (1981) informs us otherwise. Of the college men he surveyed, over one third admitted that they would, under some circumstances, commit a rape if they believed they could get away with it.

Male Victims

A third problem with disclosure related to professional response is the denial of the male victim. Porter (1986) lists five reasons for negation of male victimization: 1) the lack of information on the issues, 2) pervasive social habits such as the use of female pronouns in referring to any victim of SA, 3) the focus exclusively on males as offenders, 4) the silence regarding the existence of male rape victims, and 5) the almost total absence of information about adult male survivors of SA and rape. These points are well worth considering. Porter cites a unique series of studies of confidential self-reports of child molestations committed by 411 nonincarcerated child molesters who were being evaluated at the University of Tennessee. Although the results cannot be generalized because of the unique nature of the research design and the participants, the results are staggering. On average, paraphiliacs acting against females had committed 107 acts each, but when the victim was male, the mean was 298 acts per offender (i.e., three times that for an offender of girls.) Furthermore, the frequency of molestations of young male victims committed outside the family was 11 times greater than the frequency against young female victims outside the home. These results suggest that by focusing on the incidence and trauma of incest, many female victims are being recognized, while young males, who may be more likely to have extrafamiliar abuse, are being overlooked. One adult heterosexual pedophile, now incarcerated, attests to the pervasiveness of unreported young male victims. Sodomized by his grandfather when he was 10 years of age, as an adult, he raped hundreds of boys anally, including 200 boys in a single summer:

> Most of the kids were hitchhikers in their mid-to-late teens. I would say that about 90 percent of them were 14 or 15. I would pick them up sometimes every day, sometimes three or four times a week. One night I picked up two boys who

> were on their way home from a party. They were both 15. They got a description of the car and of me and reported it. The following month I was driving through the same town and the cops recognized the description of the car and pulled me over and brought me downtown. As far as I know, out of the couple of hundred kids that summer, they were the only two who reported it. (quoted in Porter, 1986, p. 5)

Porter cites numerous studies of clinicians who specialize in the treatment of sexually abused children and support the close-to-equal or equal-risk theory of victimization:

> I think the ratio is alot closer to 50:50, though I won't venture a guess because I haven't devised a methodology for measuring it. But what I *do* know is that the boys I see who are molested tell me about other boys they know who were molested with them. I have kept track of those figures, and the ratio I come up with regarding boys who report and boys who do not report is 1:10. For every boy that I have treated this year, I know about 10 other boys who were molested who are not being treated. (p. 6)

Other studies also confirm that sexual victimization in childhood and offending behavior may be inextricably linked. In personal interviews with incestuous fathers, for instance, Giarretto (1982) found that 80% admitted they had been sexually abused as children, but very few had ever reported the abuse. As Sgroi (1989) aptly puts it, "No program for the prevention of sexual abuse is complete if it does not encompass the treatment of the perpetrator" (p. 326). In the case of young males, the two may be as one.

Credibility of Witness

Often, the victim is the only witness to CSA, and corroborating evidence may be minimal or absent. As discussed above, both human service and legal professionals play important roles in the investigation of allegations of SA. These two groups of professionals have different training and experiences (e.g., legal professionals often have no background in child development). Thus, they may vary in the way they structure and conduct interviews with child witnesses and in their opinions about credibility and measurement.

Recent changes to the Canadian Criminal Code and the Canada Evidence Act (Bill C-15) were long overdue. This act makes it permissible for witnesses under the age of 18 to testify behind a screen or outside the courtroom via closed circuit television, allow the use of videotaped testimony, permit child witnesses to give unsworn testimony, eliminate the requirement of corroboration, and abolish the recent-complaint rule. Similar changes also have been made in the United States.

The importance of the child's account of the events has raised concerns about the credibility of the child's testimony (i.e., a false testimony). A more complex issue is the concern that false allegations may result from accusations that have been improperly elicited by professionals: "Professionals who have a prima facie belief in the truthfulness of the child's statements may conduct their interviews with the child in a biased manner that will confirm their assumptions rather than investigate a variety of possibilities" (Coolbear, 1992). Because their testimony is extremely important, children may be subjected to numerous interviewers from both legal and human service professions. In a survey of video- and audiotaped interviews, Wakefield and Underwager (1988) conclude that "the behaviors of the adults appear more geared to extract testimony rather than to allow children to tell their own accounts free from pressure and suggestion" (p. 36).

Aside from the problem of asking too much, Gardner (1992) cites an example of interviewers asking too little:

> Masturbation is one of the most commonly referred to symptoms of sex abuse. Examiners need to get specific information regarding the history of the masturbation, especially regarding whether it antedated the time of the alleged abuse....Zealous examiners will consider any degree of

> genital stimulation, no matter how transient and no matter how rare, as an indicator of sex abuse. They ask no questions about the age of the onset, the frequency, the intensity, and orgastic response. Examiners who fail to ask these questions are not in a position to determine whether the child has reached a level of excessive sexual stimulation. (p. 154)

Issues considering the credibility of children's testimony, children's susceptibility to suggestion, and the consequences of false allegations must motivate researchers to develop interviewing strategies that will lead to a full and truthful account of what has occurred. Similar reliability measures and strategies are required for accountability in adult cases alleging SA in their childhoods.

Summary of the Review of the Literature on CSA

The purpose of this thesis was to develop a sexual abuse information form (SAIR) that can be used as a handy multipurpose tool for professionals concerned with children who are current victims of CSA and adults who allege SA in their childhoods. In order to generate items for SAIR, a number of steps were taken as explained in the Method section of this thesis. The first of these steps was a review of the literature on the phenomena associated with CSA.

A review of the literature revealed a vast number of controversial issues. I recorded these issues and sorted them into five large categories for simplification of the controversial issues in CSA: (1) Part One describes issues around the concept of CSA as its definition changes through historical periods. It also includes current concepts of sexual deviance. (2) Part two concerns issues over the incidence, prevalence and the latest trends in CSA. (3) Part Three raises the question of the etiology of CSA. There may be precipitating factors in its transgenerational progression that determine principles of abuse (patterns in the victim's family, vulnerable populations, offender personalities and tactics). (4) The fourth section reviews the controversy over the short- and long-term effects on CSA victims and their significant others. Sequelae are viewed from the perspectives of individual response on the trauma continuum, developmental stage outcomes, and possible syndrome specific focuses. (5) The last section describes possible overzealous response by some clinicians and researchers who claim underresponse by the justice system. Increasing litigation suggests the need for a balanced response among clinicians.

Confusion and Increasing Accountability

This literature review shows that although we have learned a great deal about CSA, it remains a phenomenon of which there is yet much to be learned. Since our knowledge appears flawed due to the overwhelming number of factors associated with research variables, it is important to recognize that few statements should ever be accepted as representing a truth about this field:

> Unfortunately, the current literature is rife with authors' assumptions that are presented as truth or permanent knowledge, and we believe this tendency is dangerous. Even basic assumptions-such as, any sexual encounter with an adult is harmful to a child, or therapy is beneficial to all victims of CSA-should not be accepted as fact. (Haugaard & Reppucci, 1988, p. 376)

The group of sexually abused children and adult survivors is so heterogeneous that it remains to be seen whether research will be able to capture the group as a whole in a way that would verify SA without incurring a high false positive or false negative incident rate. In the rush to respond to the needs of so many victims, some fundamental errors have been made by well-meaning professionals and paraprofessionals. While it is important to be aware of techniques which may be detrimental to the progress of arresting CSA, it is also important to forge on developing new and improved methods of assessment and intervention.

There is a vast range of attitudes regarding CSA. Many professional and laypersons are becoming much more skeptical about allegations, interviewing techniques employed in the course of a disclosure, and treatment approaches that are suspect to iatrogenesis of MPD. Indeed, it appears that parts of the literature on CSA are becoming more, rather than less, controversial. Consequently, therapists are having to become far more accountable. Currently, a "backlash" exists against therapists as litigation problems increase in the counselling industry.

The development of SAIR is in response to this changing climate and to the many controversial and confusing issues in CSA as evidenced in this review of the literature. Whether the client is a child or an adult survivor, SAIR is designed to be a handy reference to the manifold factors that one needs to be aware when assessing, diagnosing, and treating victims of CSA. As a reference to the characteristics of each victim's experience, it can be used as a form of accountability for professionals for fund raising, case conferences, or instances where the file may be subpoenaed by the judicial system. In addition, the progress of a client may be monitored through changes in recorded sequelae. SAIR can also be used to provide data for ongoing research into possible hypothesis-driven patterns or syndome-specific behaviors resulting from CSA.

Chapter Three
PROCEDURES IN THE CONSTRUCTION AND APPLICATION OF SAIR

Reliability and Validity Considerations for Item Generation

The purpose of this thesis was to develop the Sexual Abuse Information Form (SAIR) to aid professionals working with victims of child sexual abuse (CSA). SAIR has four central purposes: to provide reliable and valid data collection for research, to aid clinicians with statistics required for funding and accountability, to act as a therapeutic assessment and treatment tool, and to increase awareness of a realistic assessment of the incidence and prevalence of phenomena associated with CSA.

The idea of a sexual abuse information form that can be used as a handy tool for the claims made upon it thus far (i.e., a reliable and valid tool to collect data for research, assessment, treatment, and accountability) raises key questions related to its reliability and validity. Numerous factors mediate the generation of items during the process of developing an instrument and reliability and validity factors are major considerations throughout the entire process. This chapter provides a step by step account of the procedures undertakeken to develop SAIR items.

The development of SAIR was an ongoing process and took three major phases, each phase having its own steps. Phase One involved a review of the literature on phenomena associated with CSA. This first step allowed a framework of five large controversial areas from which to generate categories of items, thereby setting out the format for SAIR. An explanation of the methods used to generate items during this first phase is provided in this chapter followed by a clarification of some controversial terms defined in SAIR. Phase Two involved refinement of the larger constructs into smaller discrete items. This was accomplished by using a sample of files from individuals receiving counselling for CSA at the Victoria Child Sexual Abuse Society (VCSAS). Feedback from counsellors of the clients contributed to further changes in SAIR during the data collection process. The third phase consisted of revisions to the refined version of SAIR. Input from other professional sources as well as restrictions in coding data for computer analysis contributed to the refinement of SAIR as a research tool. The procedural steps involved in each of the three phases are explained in this chapter.

Phase One: Determining the Framework for SAIR Items

Review of the Literature

Chapter Two provided a review of the literature on controversial issues associated with the phenomenon of CSA. These issues were convened into five large areas for discussion of the research findings to date. The five areas of controversy concern past and current definitions of CSA; incidence, prevalence, and latest trends; possible precipitating factors in victim-offender demographics; short- and long-term sequelae following CSA; and balance and accountability in professional response to alleged CSA.

Following this step the first SAIR items were generated. The study of child sexual abuse is a new area of research for the humanities and the sciences. As such, its variables seem incalcuable. Those who are attempting to discover or explain some of the basic tenets of CSA are struggling to define appropriate and measurable constructs. Unfortunately, universal consistency in defining almost any construct is most often nonexistent.

The items chosen for SAIR are, of necessity, categorical (discrete variables). Even items which, in theory, are continuous, are also treated as discrete variables. Although it is recognized that individual sequelae are often continuous variables (degrees of fear or compliance or anger), they are categorized as either "yes" (the presence of that symptom is evident at the time of counselling) or "no" (no presence of symptom at the time of counselling).

The first items were arranged together into four convenient sections in SAIR. The first section (**Part A: Victim Demographics**) holds items concerned with information about the victim's personal statistics (e.g., age, gender, disabilities, ethnicity), information about the discovery or disclosure, when the abuse began and how it was terminated, and family demographics (e.g., number of siblings, marital status of mother). These items were chosen so that one could efficiently obtain a large amount of information about the victim and his or her family.

The second section (**Part B: History of Abuse in the Family Genogram**) is able to condense a great deal of information on one page by using two grids in conjunction with a 13 point code: The code is concerned with the primary victim (i.e., the VCSAS client), and his or her relationship to someone listed in 13 items of choice: (1) father; (2) stepfather, father substitute (3) mother; (4) stepmother, mother substitiute; (5) grandfather or substitute; (6) grandmother or substitute; (7) other male relatives (brother, uncle, cousin, brother-in-law); (8) other female relatives (sister, aunt, cousin, sister-in-law); (9) other relatives (gender unknown); (10) residential position of trust (foster parents or siblings); (11) nonresidential position of trust (teacher, doctor, babysitter); (12) known and trusted acquaintance (neighbor, parent's mate, friend, peer); and (13) stranger.

The first grid in Part B of SAIR is used with the relationship of offender and victim code. The grid has six columns, two columns (offender and victim) are subsumed under the heading **Relationship of Offender and Victim** and four columns fall under the heading **Type of Abuse** (sexual, physical, emotional, neglect). It is crucial to fill in the grid using the code as related to the primary victim (client). The following example is provided to explain how the two frameworks interlace:

The intergenerational hypothesis speculates that a female victim of CSA is likely to come from a family where her own mother was also a victim of incest (Gelinas, 1988). The typical scenario in these cases is the daughter fulfils the mother's role as both homemaker for her siblings and sexual partner for her father. The father is seen as sexually exploitive, the mother as neglectful, and the child as unfortunate to be caught up in a perpetual cycle of CSA. If this young female victim were a client at VCSAS then the number

5 (grandfather from the relationship code) would be placed in the offender column and a 3 (mother from the relationship code) would be placed in the victim column. A tick would be placed under sexual abuse. On the next line, a 6 (grandmother) would be placed in the offender column and a 3 (mother) would be placed in the victim coulumn. A tick would be placed under neglect.

A second grid of two columns for substance abuse (alcohol and drugs) can also be used with this code. For example, if both grandparents in the above scenario abused alcohol, then a 5 and a 6 would be placed in the alcohol column. If the victim's mother currently abuses alcohol, a 3 would also be placed in this column. If the mother's sister currently abuses drugs, an 8 (aunt) would be placed in the drugs column. Additional space in the bottom right corner of Part B in SAIR is allowed for anecdotal notes regarding substance abuse.

These items are in response to the literature on types of intergenerational abuse in families where CSA occurs. For example, it would be interesting to compare genograms of victims of intrafamilial and extrafamilial child sexual abuse to see if there are significant differences in the number or type of sequelae subsequently experienced by the victim.

The third section of SAIR (**Part C: Alleged Offender Demographics and Abusive Incidents**) includes items concerned with the offender demographics and the abusive incidents. Many items in this section had to be determined from constructs that had either not existed previously or were too vague in the literature to be of any usefulness for research (e.g., patterns in time, place, tactics employed by offender). Other variables in this section deal with the criminal investigation (classification of SA as intrafamilial or extrafamilial, type of sexual abuse (levels of intrusiveness), reporting procedures, and outcome of the investigation. These items were included in the development of SAIR because much information about the offender, the onset and patterns of abusive incidents, and the outcome of an investigation is required if we are to have a reliable method of recording the victim's account of phenomena associated with CSA. A complete picture would result in cases of family counselling as a result of incest where both the victim and offender can contribute to the scenario. An important consideration from the review of literature is that victims of CSA often end up being revictimized by someone other than the original offender. Therefore, section three is designed as a back-to-back one page insert that can be used whenever a client has more than one sexual offender to report. Number of offenders is a different concept than number of offences (i.e., the actual number of times a victim was subjected to abuse either by one or more than one offender).

The fourth section (**Part D: Victim Sequelae**) has items related to the sequelae a victim experiences during counselling. These items were grouped into seven subtopics where personal and traumatic changes had been experienced by victims and reported either by the victims themselves or by their significant others: school, work, or social activities; personal relationships; sexuality; bedtime; hygiene; behavioral or emotional symptoms; and medical or somatic complaints. These seven groupings were selected for convenience in accessing the sequelae items. There was no attempt to statistically assess the validity of the item groupings. While that research would be welcomed, it is beyond the scope of this thesis. Rather, items were placed in the seven groupings by this author and then each counsellor at VCSAS had his or her say in adding, revising, deleting, or moving items. This consultation process is a measure undertaken to enhance construct validity and will be discussed further as a step in phase two.

Generation of SAIR Items

Much of the factual information discovered during the review of literature regarding SA incident(s) was readily categorized (male and female for **gender**) and some could be easily converted into levels once it came time for data input into the computer. Examples include the addition of preschool, school, adolescents, and adults as levels for the variable **age** or one, 2-10, or more than 10 for **number of offenders**.

It is because many of the larger, categorical constructs in CSA literature are vague that allowance was made for anecdotal responses on the original SAIR outline. One example is the item **ritual or satanic abuse alleged by victim or others**. Several lines are left to provide an explanation. However, such a report should be further investigated by proper authorities. It is beyond the scope of SAIR to adequately record all the necessary documentation.

Most items were refined into variable levels in Phase Two of the development of SAIR. Many of the constructs (e.g., **reason abuse terminated**, had to be defined before its items could be determined. These types of categorical constructs yielded discrete items with varying numbers of choice. In the case of this variable, six levels were designed to cover all definitional possibilities: unknown, victim or someone else disclosed abuse, offender moved or was removed from position or relationship, victim moved or avoided offender, legal or professional intervention regarding child protection, and offender lost interest or terminated abuse.

Another example of a categorical construct that has been loosely referred to in the literature and required defined items is **disclosure or discovery situation**. It has 10 choice possibilities: unknown, victim told mother/mother substitute, victim told another family member or friend, victim told staff member at school, victim told another professional outside of counselling, victim told during counselling, someone else told on/for victim, offender and victim discovered in sexual encounter, victim was sexually or behaviorally acting out on self or others, and medical or physical evidence.

A third example of a newly defined categorical construct is **outcome of the investigation**. It is comprised of 12 items including three that allow space for additional specific information concerning the item: offender sentenced to a prison term (specify), offender sentenced for a period of probation (specify), offender sentenced to receive forensic or mandatory counselling, offender sentenced to complete community service hours, offender received restaining order to contact victim, charges were dropped because victim recanted statement, charges were dropped due to insufficient evidence, individual was acquitted, investigation in progress, diverted, unknown, and other (specify).

A great number of SAIR items are presented in the above manner, as choice items under larger categorical constructs. Many of the items for these constructs were defined during Phase Two of the development of SAIR (i.e., during its inception on 452 anecdotal files of CSA victims receiving counselling). Item possibilities were discovered during this process that had failed consideration in the initial framework of SAIR. Examples of other categorical variables determined in this manner are **classification of abuse, reason abuse not reported, type of sexual abuse, time and place patterns in regard to abusive incidents, additional abuse tactics used by offender, specific mental or physical disability**, and **ethnocultural background.**

A third method of determining items for SAIR was through revising existing constructs in the literature because they are inconsistent or inadequate. Wherever possible, however, definitions for constructs are kept close to the existing literature in order to maintain some sort of universal consistency among researchers. For example, **type of sexual abuse** was derived following a study by Russell (1988) on the incidence and prevalence of intrafamilial and extrafamilial sexual abuse of children. In her study, she used three categories of seriousness of incest (i.e., very serious SA, serious SA, and least serious SA). Some of Russell's wording or ideas are incorporated into SAIR, for example, the definition of "force," which includes both physical force, the threat of physical force, or inability to consent due to physical helplessness. But following consultation with a number of colleagues who expressed concern about the degree of trauma experienced by victims who were victimized without any physical contact by the offender, a fourth level of "seriousness" of SA was added. **Least intrusive sexual abuse** does not involve any physical contact and includes scenarios of exhibitionism, an obscene phone call or gesture, exposure to pornographic materials, or sexual harassment.

Furthermore, the name of the variable was changed because the semantics appeared to reflect the stereotypical belief that the "seriousness" of an encounter is related to the degree of intrusiveness (e.g., "It was only fondling, so what's the big deal?").

This researcher feels that neither the literature nor professional experience with victims warrants this assumption. Certainly, all SA incidents are serious and cannot be determined by the degree of intrusiveness. Consequently, the name of the construct being measured was changed to **type of sexual abuse,** and its four items are determined by degree of intrusiveness.

It is important to understand that the items are ranked by degree of physical intrusiveness and do not intend to imply degree of psychological or physical trauma ("seriousness") subsequently experienced by the victim. Therefore, a brief example of instances that meet the criteria for each type of sexual abuse is provided along with the item. The categories of this construct are discussed in the Definition of Terms section below.

Another example of refining vague and inconsistent constructs concerns the **relationship of offender and victim**. The categorical variable is **classification of abuse** with three possibilities: no information, intrafamilial, or extrafamilial. However, clearer definitions for criteria to determine the classification for intrafamilial or extrafamilial is provided on SAIR as part of each item. The intent is to avoid confusion for those filling out SAIR and therefore aid in consistent data recording. The code consists of 13 items, nine refer to intrafamilial relationships and 4 refer to extrafamilial relationships. Those in intrafamilial "susbstitute" positions (e.g., mother's mate as a father substitute) must have been in the position for 2 years to qualify as a substitute). Relationships considered as **intrafamilial** include: **1**: father; **2**: stepfather or substitute; **3**: mother; **4**: stepmother or substitute; **5**: grandfather or substitute; **6**: grandmother or substitute; **7**: other male relatives (e.g., brother, uncle, cousin, stepbrother, brother-in-law); **8**: other female relatives (sister, aunt, cousin, stepsister, sister-in-law); and **9**: other relatives (gender unknown). **Extrafamilial** relationships include: **10**: position of trust in residential settings (e.g., caregiver, respite worker, foster parent(s), foster siblings); **11**: nonresidential position of trust (e.g., teacher, daycare worker, babysitter, other professional); **12**: known and trusted acquaintance (e.g., neighbor, family friend, boy/girlfriend, club leader, peer, parent's mate); and 13: stranger. The relationship of offender and victim code is used twice in SAIR; once in Part B for historical abuse relationship, and once in Part C for the primary victim's relationship. The use of the same code further tightens the reliability of response to categories.

The fourth method of determining items for SAIR is found primarily with the sequelae items. Several items act as constructs that provide internal items of choice. These items have been grouped for efficiency due to space restrictions in SAIR. In these items, any or all of the circumstances relevant to the individual's symptom can be easily circled: Dresses inappropriately: seductively or layering (Circle). Another example: Has memories or fears of choking, suffocating, stuttering (Circle). A final example: Is very shy or withdrawn: Avoids peers, men, or women (Circle). Other sequelae items provide space for additional information: Touches adults, children, or animals excessively or inappropriately (Circle), (Explain); Shows a sudden behavior change (Explain); Displays intense fear of a specific person (Specify); or Current prescriptive medication (Specify).

Sequelae items were grouped into seven categories during Phase One: school, work, or social activities; personal relationships; sexuality; bedtime; hygiene; behavioral or emotional symptoms; and medical or somatic complaints. These sequelae categories were chosen to assist clinicians with assessment of trauma for the purposes of treatment intervention.

SAIR items refer to those features which distinguish one client from another: age, gender, ethnicity, birth order, family demographics, relationship to offender, sequelae, and so forth. The rationale used to determine these items involves four methods that are explained above. Many of the larger constructs are broken down into smaller items. Some are clarified with choices provided along with the item, for example, those relationships considered as extrafamilial. However, there are terms which are mentioned as part of this study on the construction and implementation of SAIR that require clarification in the Definition of Terms.

Definition of Terms Used in SAIR During Item Testing

Aboriginal: This term refers to the indigenous populations of Canada, which are the Dene, the Inuit, and the Metis.

child: In British Columbia a child is considered to be anyone less than 19 years old (as in this study). This law varies in provinces and states. For example, a child is less than 18 in Alberta.

continuum of coercion: This term refers to the wide variety of tactics employed by the sexual offender and experienced by the victim. For example, a child may be groomed to engage in sexual activity that becomes increasingly more intrusive through time. The tactics employed become so pervasive and insidious, that the victim is often unable to distinguish affection from the sexual abuse.

extrafamilial child sexual abuse: This term will refer to any kind of exploitive sexual contact or noncontact (e.g., obscene phone call, exhibitionism) that occurred with persons unrelated by blood or marriage or acting in such a position before the victim turned 19 years old. It includes hired positions of trust in residential settings (e.g., foster family members, respite workers, or caregivers) and nonresidential settings (e.g., teachers, daycare workers, clergy, babysitters). Neighbors, volunteer club leaders, peers, and family acquaintances also fall in this category.

incidence: In this study, incidence will refer to cases of child sexual abuse that received counselling at VCSAS within the two fiscal years of operation between April 1991 through the end of March 1993. In British Columbia, the legal age of a child is up to the time of an individual's 19th birthday. A victim of CSA has up to 2 years past this time to provide a statement to the police and apply to the provincial government for funded counselling services. Hence, the actual time the abuse occurred is not necessarily within these two fiscal years; the abuse may have occurred many years prior to this time period.

intrafamilial child sexual abuse: This term will refer to any kind of exploitive sexual contact or noncontact that occurred between relatives, no matter how distant the relationship, before the victim's 19th birthday. In addition, this term applies to those acting in a relative's position for a period of at least two years (e.g., stepparent or commonlaw parent or stepsibling, brother-in-law or sister-in-law).

prevalence: In this study, prevalence will refer to the percentage of individuals receiving counselling at VCSAS who were victimized by a particular experience of sexual abuse, whether the experience occurred once or many times.

violence: The term refers to the violation of the basic integrity of human beings. It is a pervasive term describing all forms of abuse, and is not simply restricted to abuse involving physical force. The four classifications of abuse which are considered to involve violence are physical, sexual, emotional, and neglect.

sexual abuse: In his summary of research issues in CSA, Finkelhor (1986) acknowledges the problem of lack of clarity in defining sexual abuse. In regard to the types of acts that should be included as SA, he says there are two factors researchers need to consider:

> If researchers are too restrictive in the definition of abuse, they may never be able to test their own assumptions. Thus if encounters with exhibitionists are excluded on the grounds that this is not serious abuse, then the question of how serious such encounters are is never answered.

> On the other hand, if researchers are too liberal in their definition, their research may be rejected as meaningless by the public and professionals. Some researchers have included any childhood sexual experience that the subject felt was unpleasant, including seeing a parent naked or having a disappointing first sexual experience. These seem beyond the pale of what is commonly defined as sexual abuse.
>
> Given the embryonic status of the field, in our estimation, investigators should be broad rather than narrow in their definition. (p. 202)

There is no consensus among researchers and practitioners about what constitutes sexual abuse, what age defines a child, nor even whether the concept of child sexual abuse is preferable to others such as sexual victimization, sexual exploitation, sexual assault, sexual misuse, child molestation, sexual maltreatment, or child rape. Furthermore, these terms have frequently been limited to sexual behavior that occurs between adults and children. Consequently, cases in which children are raped or otherwise sexually abused by their peers, younger children, or children less than five years older than themselves are often dismissed as not meeting criteria for child sexual abuse. In this study, any of the above terms may be used interchangeably. However, there are two aspects to this term which require clarification.

The first is concerned with the issues of consent and the age difference in the relationship between an offender and a victim. Wells (1990) provides us with an informative book, Canada's Law on Child Sexual Abuse, in which the Criminal Code of Canada states that any sexual activity without consent is always a crime regardless of the age of the individuals. It also states that children under 12 are never considered to be able to give consent. Children who are age 12 or 13 are also deemed unable to consent to sexual acts except under specific circumstances involving sexual activity with their peers (i.e., someone less than two years older than themselves). While it is recognized that two *adolescents* engaged in consensual sexual activity does not constitute sexual abuse, there is no law about two *young children* engaging in sexual activity. When children are young, the behavior of the one who initiates the sexual activity is often referred to as "sexually acting out" behavior. Exactly when this sexual acting out behavior becomes offending behavior is another controversial issue in CSA. For the purposes of this study, younger children who had been "sexually acted upon" by a peer age child were also considered to have been sexually abused.

The second issue which requires clarification for a proper definition of sexual abuse is a consideration of which behaviors are considered to be "sexual offences." The Criminal Code of Canada lists 16 offences that could apply to child sexual abuse. These range from non-physical contact situations such as exhibitionism and an invitation to sexual touching to other more physically intrusive acts such as vaginal or anal intercourse and on to other areas such as beastiality and juvenile prostitution. In this study, sexual abuse refers to a wide range of activities which vary according to the degree of physical intrusiveness. SAIR covers a continuum ranging from no physical contact (exhibitionism, obsene phone calls, exposure to pornography) to intercourse. Specifically the degree of intrusiveness is defined by four levels of **type of sexual abuse**: **Very intrusive sexual abuse** (completed and attempted vaginal or anal intercourse, cunnilingus, fellatio; forced and unforced); **Intrusive sexual abuse** (completed and attempted genital fondling, simulated intercourse, digital penetration; forced and unforced); **Less intrusive sexual abuse** (completed and attempted acts of intentional sexual touching of clothed breasts or genitals, forced and unforced); and **Least intrusive sexual abuse** (no physical contact such as exhibitionism, obscene phone call or gesture, exposure to pornographic material, sexual harassment).

Rationale to Refine Items in Phase Two

The construction of SAIR required its larger constructs to be defined into smaller items. In order to generate new items and refine constructs, it was necessary to use an appropriate sample of files to collect the information contained within. Using these data helped to determine the items. For instance, whenever I read of a symptom or situation I had not thought to include in SAIR, a new item was created. Sometimes, other counsellors suggested items to include based on their clinical experiences. No items were rejected because the purpose of SAIR was to cover the content of CSA phenomena. This phase of the methodology raises issues of validity that can be addressed as follows:

Face Validity: Although SAIR is a tool to record information rather than a test instrument per se, it is important for counsellors and other professionals who may wish to use an instrument such as SAIR to have a a sense of its legitimacy. Face validity is thought to motivate the users of an instrument. One such way to achieve this end is to create SAIR so that it appears to cover the area it is designed to measure; in this case, the phenomena associated with sexual abuse of children and those with special needs. Determining items using the information available in the file sample increased the probability of discovering more items to include in SAIR.

Content Validity: This term refers to the systematic evaluation of a test by experts in the test's related field. Again, SAIR is not a test and therefore, this term is not entirely appropriate for this thesis. However, the construction of SAIR was completed in as systematic a procedure as possible using three separate phases. Throughout each phase, the opinions of professional colleagues were considered for input into SAIR. In this way, SAIR items are designed to sample the domain of information related to CSA. This includes phenomena regarding those individuals with disabilities.

Construct Validity: The construction of SAIR did not include any formal methods of statistically evaluating its constructs. This is required for future research on SAIR if it is to be determined as a statistically valid instrument. Construct validity often is determined by correlations with other tests that purport to measure the same construct (convergent validity) or a different construct (divergent validity). An instrument must be sensitive enough to indicate differences among its items. The file data used to construct

SAIR helped to distinguish various items. The same data can also be analysed in the hope that some convergent or divergent differences among groups responding to the items would be evident. In this regard, a form of construct validity is suggested by the sensitivity of the instrument to determine differences in items.

Phase Two: Testing SAIR Items on a Sample of Client Files

Phase One of SAIR development involved a review of the literature on CSA that resulted in a rough framework of specific items and some generalized item categories that fell into four major sections: victim demographics; historical types of abuse in the victim's family; offender demographics, tactics, and outcome of an investigation; and sequelae experienced by the individual at the time of counselling.

The second phase required testing out these roughly generated items on a sample of files from individuals who were victims of CSA. The process of testing SAIR items on information taken from files provided the opportunity for revising some items, discarding others, and discovering new items altogether. For example, **number of siblings**, and **birth order** were more difficult to quantify than originally thought. This was due to the number of blended families and, therefore, new categories including half siblings and step siblings had to be developed. This raises validity concerns over the construct of birth order rank within a blended family. For this study, it was determined that the birth order rank included half siblings or step siblings if that individual had been in a live-in sibling role for two or more years.

Another example of how a variable category was generated and then refined is **mental disability** and **physical disability**. These two items had been generated during Phase One of the development of SAIR but, it was during Phase Two that items were added for clarification. **Specific disability** is coded: (1) auditory handicap, (2) visual handicap, (3) mobility problems, (4) neurological impairment, (5) developmentally delayed (IQ < 70), (6) autistic behavior, (7) borderline/low average intelligence (IQ 70-89),

(8) learning disabled, (9) attention deficit disorder with or without hyperactivity (ADD, ADHD), (10) fetal alcohol syndrome or effect (FAS, FAE), (11) psychological maladjustment, (12) other (Specify).

These items were generated in the refinement process of categorizing the types of disabilties experienced by the clients as recorded in the VCSAS files and in consultation with the counsellors of the clients. The reliability of the data collected from the files depends on the trustworthiness of the clients reporting the information during counselling, the counsellor adequately recording all pertinent information in the file, the methods used to obtain the information from the files, and the measures taken to code the data into a statistical computer program. Each of these areas is addressed during the procedures in Phase Two and Phase Three.

Decision to Select the Victoria Child Sexual Abuse Society as the Agency for Sample of File Data

SAIR was tested on a sample of 452 anecdotal files at the Victoria Child Sexual Abuse Society (VCSAS) in Victoria, British Columbia. The agency provides personal safety skills and treatment for children, adolescents, and adults who allege, or whose guardians allege, victimization of child sexual abuse. As a sample source to test the validity and reliability of SAIR, VCSAS provided unique opportunities:

1) The agency has been in successful operation for over a decade and operates with counsellors well trained in the field of sexual abuse.

2) Files are kept on victims and their families since the agency's inception one decade ago and they improve in consistency of format over time. The last two fiscal years were the most consistent in format and provided an adequate sample size for this study.

3) Although the clientele at VCSAS would be considered a clinical population, a closer inspection reveals a broader, more heterogeneous population than that often found in a typical clinical study. As a public agency, factors such as gender, ethnicity, and mental health status could be considered in the data. As a family

counselling agency, it provided a more rounded perspective to the file data by not only treating children and adolescents, but also involving the parents and siblings as well. In addition to these qualities, there was no reason to suspect any bias that would be considered a hindrance to valid research such as an over abundance of one type of relationship category (i.e., intrafamilial versus extrafamilial versus both types of abuse) or the ability to meet the cost of counselling. Funding is provided for all clients.

4) VCSAS provides treatment for people with mental and physical disabilities, most of whom do not reside in institutional settings. This provided the possibility of comparing the sample population of people with disabilities to the nondisabled population. The data can also be used to compare people with disabilities internationally through a University of Alberta research project headed by Dr. R. Sobsey on disabled individuals who have been sexually abused primarily in institutions. (See Appendix B for permission to share data.)

5) A new British Columbia government funding policy allowed increasing numbers of Aboriginal children and their families to use the services of VCSAS.

6) This researcher had worked as a counsellor at the agency and was familiar with the clientele, the staff, the filing sytem, and the procedures required to collect the data. In addition, the members of the VCSAS Board of Directors were pleased with the opportunity to have research completed using the agency's files as they wished to increase their knowledge of factors associated with their particular clientele. (See Appendix C for consent form to collect data.)

Selection of Files

Data were collected from 452 files of children and adults following referral for treatment of child sexual abuse. The files represent the incidence of all those victims receiving counselling at VCSAS during the 2 fiscal years of operation between April 1991 through to the end of March 1993. Information in the files consisted of counsellors' anecdotal assessments and reports of ongoing clinical interviews so that the file report began when clients entered treatment and continued as it progressed. The last two fiscal years of the agency's operation were chosen because they were the most relevant to current issues, had the most consistent format, and included target groups of persons with disabilities and Aboriginal peoples.

The nonrandom selection of files serves to increase the heterogeneity of the sample because it includes all clients with disabilities who were receiving funding from a unique government program. Since funding for counselling comes from various sources, a target group of Aboriginal people seen at the center could also be compared. Another possible target group within this sample are files of parents of the victim (usually mothers) who were also funded for counselling because of their own unresolved issues of CSA. These issues have often lain dormant until the disclosure or discovery of their children's SA and subsequent counselling. These cases are not uncommon and are a concern for the staff at VCSAS because the mandate of the agency's Board specifies that funding for individual counselling goes to children.

There was a second advantage to using the last 2 years of file data at VCSAS. Although anecdotal files had been completed by 15 individual counsellors, the frame of the format had been standardized in the last two years to meet the funding requirements by the British Columbia Ministry of Health. This added to the probability of more consistent data collection within the files.

Third, all except two of the staff were still working at VCSAS, and therefore, it was quite easy to clarify any problems concerning the data collection. A fourth advantage is that the last 2 years of operation at VCSAS would be the most relevant for recording current issues in the literature, for example, the concept of dissociation.

A final advantage to selecting all the files within two fiscal years of operation is that there is more likely to be a representative picture of clients at all stages in the counselling process (i.e., some will be beginning counselling, some may have been in counselling for several months, some will have completed it. A sampling distribution would show open files (current clients) and closed files (individuals are no longer clients).

Procedural Steps to Collect Data

This researcher read each of the 452 files in the two fiscal years of operation selected for the sample. One SAIR form was used per file. However, Part C of SAIR was repeated in cases where a file contained evidence of more than one offender. SAIR items were matched or "fit" with the relevant information contained in each file. Additional information was added to SAIR whenever a vital point to consider in revising SAIR was discovered. Items and their categories were defined and refined until a fit could be found. Once the information from all files had been transferred to related SAIR items, this researcher met with each counsellor to ensure agreement on each fit. This discussion with the counsellor of each client's file used in the data collection process clarified any descrepancies or questions held by this researcher. Quite often, the counsellor was able to supply the information requested or to correct some misunderstood item.

Summary of Phase Two

Items were generated for SAIR following a review of the literature and through consultation with colleagues and other professionals working in the field of CSA. A pilot form was drafted, and the two most recent years of operation were set as the criterion for the selection of files. All files were used in the data except in a few cases where a child may have received personal safety counselling sessions with a sibling who had been sexually abused. In special cases, a separate file was created for the sibling who did not allege SA by the offender, but who may have suffered other types of injustices, for example, physical abuse. These files were not included in the sample of the last two fiscal years because they did not meet the criteria of a SA victim per se.

Prior to the data collection, clients had given consent to VCSAS to use their files anonymously for the purposes of research, and VCSAS had agreed to share the data with the Sexual Abuse and Disabilities Project at the University of Alberta.

This researcher read each file and recorded the information on a corresponding SAIR. Revisions to items were made and additional items were discovered during this process. This "fit" of information contained in the file with a matching item on SAIR helped to define and refine SAIR items. Some of the files were active, and some were inactive (i.e., counselling had terminated either temporarily or permanently). Files were coded 1 through 452. Each offender was recorded to match the victim. In those cases where there was more than one offender, an additional section C was recorded and coded to the victim. Following this recording procedure, the researcher met individually with each of the counsellors to discuss the files that were selected for inclusion in this study. Each file was reviewed in consultation with the client's counsellor once more. This provided a more reliable account of actual events, and information was added or adjusted as necessary.

The data collection process of Phase Two in the development of SAIR took approximately six weeks and allowed for the refinement of items. These newly defined categories of items could now be used for variable selection and statistical input during phase three of the development of SAIR.

Limitations to the Development of SAIR

The reliability of the data collected from the study depends upon the extent to which clients reporting the information and the methods used to obtain the information can be trusted and relied upon. There are a few considerations regarding limitations to the file sample that need to be addressed:

1. The nonrandom sample used to determine variables for SAIR is one of convenience and not a true representation of the population of sexually abused victims. Rather, it consists of a highly specific sample of sexual abuse victims in North America (i.e., those who have attended counselling sessions at the Victoria Child Sexual Abuse Society in British Columbia.) Hence, it is expected that the

majority of victims will come from this region of Canada, although other regions where the abuse occurred will be recorded. It is also recognized that clinical samples are samples of convenience. Therefore, generalizations to the population of victims of sexual abuse from their data are limited because there may be other factors which prevent victims from reporting their abuse and discourage them from becoming involved in counselling.

2. The vast majority of the victims were never seen by the researcher. Rather, files had been completed by various counsellors throughout the last decade. Much of the material is anecdotal since it was recorded prior to the standardized assessment forms provided by the B.C. Ministry of Health in 1991. Therefore, biases in recording the information at the time of counselling may be present, despite an attempt to minimize these (e.g., use files only from the time when the standards were issued). Another possible bias is that inherent in recording the information from the file to SAIR by the researcher. Although this bias also could be minimimized by directly confirming the data recorded by the researcher with the victim's original counsellor, not all of the original counsellors still work at VCSAS. Furthermore, the client's counsellor is likely to have his or her own bias in recording information in the file.

3. Accuracy of the data in the file depends on the victim's account and the counsellor's recordings of that account. Several studies (e.g., Young, Sachs, Braun, & Watkins, 1991) report more intense incidents of CSA are disclosed later on in counselling once the client begins to trust the counsellor. This sample of client files in Phase Two ranged from commencing counselling sessions to any stage on up in progress to the termination of counselling. Thus, there may be information that was not disclosed or missed due to the time frame restriction in the selection of files. One example is the construct **outcome of investigation.** It may take several months for an investigation to be completed and the

victim may have finished counselling prior to the recording of this information.

4. Some of the items on SAIR are readily categorized into discrete levels such as male and female for **gender**. However, many of the levels of variables were determined following the analysis of anecdotal categories from the files at VCSAS. This was in an effort to introduce new constructs and to reduce the vague generalizations around poorly defined contructs such as the **disclosure or discovery situation, patterns of abuse regarding time or place**, and **the reasons the abuse was not reported**. While the items determined were appropriate for this study, some items on SAIR may be inappropriate for other populations. Such variables could be modified or disregarded. For example, **region of residence at time of referral** contains two of its four items that relate to British Columbia. This variable could be adapted for data collection in other regions in North America. Similarly, there may be items not addressed in SAIR due to this researcher's bias in factors associated with the CSA phenomenon, and therefore, the data may be restrictive in some areas.

Phase Three: Final Revisions to SAIR Items

Phase Three in the development of SAIR followed the refinement of items during the data collection process in Phase Two. These newly defined items were used for variable selection and statistical input during Phase Three of the development of SAIR. Phase Three began with all items being coded and then running the data through the Statistical Package for the Social Sciences, (SPSSx, 1988) at the Centre for Research in Applied Measurement and Evaluation (CRAME) in the Faculty of Education at the University of Alberta. The components of SAIR at the time the items were coded are explained below.

Components of SAIR

SAIR has 143 constructs that range considerably in their specificity. For example, the construct **gender** has two well-defined categories. This is in sharp contrast to a continuous variable such as **appears depressed on a regular basis**. Because of this recognized dilemma of loosely defined constructs (e.g., Finkelhor, 1986), many of the constructs provide several items of choice, increasing the heterogeneity of items to 472. These are broken down as follows:

Part A focuses on victim demographics and has 22 constructs, for a total of 99 items. Part B highlights abuse in the family genogram and has six constructs that are crossed with each other. One of the variables, **category of offender** (e.g., father, mother, stepfather, or father substitute), has 13 possible items of response. A second variable, **category of victim,** has the same possible items of response. Both these variables have 13 items, each of which can be crossed with any of six types of abuse (**sexual (SA), physical (PA), emotional (EA), neglect, alcohol,** or **drugs**) for the offender, and SA, PA, EA, and neglect for the victim. In total, there were 130 possible choices of items. Part C records offender demographics and incident facts and has 23 items, with a total of 110 response choices. Part D lists possible symptoms known to be associated with the trauma associated with CSA. There are 91 items, with 42 additional items inherent within these larger items, creating a total of 133 possible sequelae responses. The sequelae are subsumed under seven subsections (**school or work performance, personal relationships, sexuality, bedtime, hygiene, behavioral and emotional symptoms,** and **medical or somatic complaints**).

For those interested in the specifics of coding the items, computer names for all variables coded in SAIR are provided in detail in Appendix D.

Another vital part in the revisions to SAIR during the third phase was accomplished through consultation with a number of professional sources: First there were professors and graduate students in research who offered their expertise in the coding, input, and analysis of the data. A preliminary form of content validity was assessed following the completion of SAIR for each file by this researcher and her colleagues. For example, all sequelae items were endorsed, so it was felt that each item was a valid entry in section D and was included in the revised version of SAIR. Some of the items could be collapsed into smaller categories. A few items were discarded altogether as they were redundant or lacked clarity. Some new items were included. **Specify current medications** is an example of a sequelae item suggested by one professional colleague during Phase Three. However, it should be noted that true content validity is determined systematically by experts and this was not part of the process in determining SAIR items.

The format of SAIR and the findings from the sample of files at VCSAS were presented to participants at a workshop for the Severe Handicaps Alliance for Public Education (May, 1994) in Edmonton. Counsellors concerned with SA victims with disabilities were asked for their input on the details of the items (e.g., wording, phrasing, addition or deletion of items). The terms **diverted** and **stayed** were suggested at this meeting as item additions for Part C of SAIR.

The final step in the development of SAIR required attention to its cosmetic appearance. The four parts to SAIR were laid out back to back on large paper (11 x17 inch) which is folded into a 12 page booklet (6 pages, both sides) including front and back covers. An insert page (Part C) is easily added in cases where the victim has more than one offender. Space for information that had been overlooked such as the phone numbers of other professionals that may be involved with the client (e.g., doctor, social worker, lawyer, teacher) was added on the front cover. Space for a genogram diagram is provided on the back cover.

Summary of Phase Three

Items from SAIR were given variable names and numerically coded at CRAME. Some of the larger categories of constructs were collapsed and run through a second time to clean up data and make it more presentable. Although the number of SAIR items is listed as

472, this figure continues to increase as new variables are created by converging or expanding old items.

It became clear during this final phase of the process of developing SAIR that there are many items that could be incorporated into future research statistics should they be asked during counselling. Therefore, several items are included in SAIR even though the files contained scant information on them. These data "blanks" are especially relevant to items concerned with the offender's demographics and tactics, the reporting procedures taken, and the outcome of the investigation. This author feels more heed could be focused on these areas as they may contain valuable information for the prevention, assessment, and treatment of CSA.

Summary of Procedures in the Development of SAIR

The purpose of this thesis was to develop SAIR as a convenient recording-keeping instrument for professionals working in the area of CSA. SAIR can be used as a research tool by providing consistent terms for recording data, as an assessment tool and monitor of progression in treatment, as an efficient record of accountability, and through its ongoing implementation, enhances a social awareness of the prevalence and consequences of CSA.

Chapter Three provides the blueprint of the procedures employed in the development of SAIR items. The procedural steps are divided into three large phases. Phase One concerns the construction of the framework for the format of SAIR along with the inclusion of most basic items. The format consists of four sections to SAIR: Items in Part A concern the demographics of the victim and the family; Part B is a unique setup using a code and grids to determine types of abuse in the family genogram; Part C relates to the demographics of the offender, the tactics employed, the reporting procedures, and the outcome of the investigation; and Part D provides an extensive list of sequelae items thought to be associated with the trauma of CSA. The framework for these items resulted from a review of the literature on the controversial issues associated with CSA. Phase One also describes four methods of determining SAIR items and provides a definition of terms used in the inception of SAIR on the files of the clients at VCSAS.

Phase Two consisted of the refinement of SAIR items generated from Phase One. This involved testing the generated items on a sample of 452 files at the Victoria Child Sexual Abuse Society. The rationale behind the selection of VCSAS as an agency to test SAIR items, the choice of two fiscal years in the agency's operation as the file sample, the procedural steps taken to collect the data, and the reliability of the procedures in reporting and recording the file information are all addressed in Phase Two.

Phase Three resulted in a further refinement of SAIR as revisions were necessary for coding the data into the computer at CRAME at the University of Alberta and interpreting it during its analysis. Many professionals contributed to this phase of SAIR development with their helpful suggestions for refinement or addition of items. The components of SAIR used for data entry are provided in the description of this phase. Findings from the data collected during Phase Two are provided in Chapter Four.

Chapter Four

FINDINGS FROM DATA COLLECTED DURING THE DEVELOPMENT OF THE SEXUAL ABUSE INFORMATION RECORD (SAIR)

Introduction

The purpose of this thesis was to develop the Sexual Abuse Information Record (SAIR) so that professionals working with victims of SA will have an efficient method of recording information pertaining to each individual case. By keeping a record of the relevant phenomena associated with CSA or SA of adults who are disabled or elderly, SAIR provides the professional with a valuable instrument offering several choices: a record of accountability for funding and legal or ethical issues, a reliable and consistent method of data collection for research, an assessment tool for therapeutic intervention strategies, and a method of monitoring the therapeutic process (e.g., additional disclosures, changes in sequelae during specific interventions or over the course of therapy).

SAIR was developed in three major phases: The first phase required exposure to the literature on CSA from the perspectives of child victims, adults who are vulnerable or were victimized as children, those in the response system (e.g., practitioners, child care workers, police, doctors, lawyers), and researchers. The basic framework of SAIR (Parts A,B,C, and D), construct categories, and some specific items were generated following this review of the literature. Phase Two required testing the items on a sample of 452 files from the Victoria Child Sexual Abuse Society (VCSAS). This phase enhanced the generation of new items and refined older items thereby defining large constructs into smaller items. Phase Three required coding the data collected from the sample of files into a statistical program at the University of Alberta. This resulted in the final SAIR revisions to date of this thesis.

Overview of Analysis of Data

The purpose of reporting the data collected during Phase Two of the construction of SAIR is an attempt to determine similarities and differences in findings from those in the literature. By doing so, it allows for a degree of construct validity of SAIR items to be determined. Furthermore, using chi square contingency tables to compare differences in various groups found in the files (e.g., disabled vs nondisabled) provides some confidence in the validity of SAIR items. This is because it shows items are sensitive enough to measure differences among clients.

SAIR items were coded at the Centre for Research and Measurement in Education (CRAME) at the University of Alberta using the third version (1988) of the Statistical Package for the Social Sciences (SPSSx). The analysis of SAIR items is restricted to two methods: (a) a count of each SAIR item for the sample of clients from VCSAS and, (b) a chi-square analysis of item frequencies to complement some of the major issues presented in Chapter Two. This chapter is divided into two parts to reflect findings from each method.

The first part of this chapter explains the calculation of frequencies and converts them into valid percentages. These results are presented in tables throughout this chapter. The tables are presented in a logical sequence, beginning with items from section A of SAIR, followed by sections B, C, and D, respectively. A summary highlighting the findings concludes the first part of Chapter Four.

Second, chi square contingency tables provide the probabiltities of differences in distributions among many of the items. Significant strengths in plausible relationship hypotheses are summarized in charts. As a sample of the use of SAIR in research on CSA, four areas are explored: (1) issues relating to the trauma continuum (i.e., are there significant differences in sequelae related to specific factors such as whether the abuse was intrafamilial or extrafamilial, number of offenders, frequency of incidents, degree of intrusiveness, concurrent abuse, and duration of abuse), target populations or gender issues within the sample population?), (2) issues relating to recognition of target groups within the sample, (3) issues relating to gender differences, and (4) issues relating to the intergenerational hypothesis.

Frequencies of Response to Items

(Items as they appear on the SAIR will be highlighted.)

There were 452 files in the sample which can be broken into a variety of target groups: those 51 individuals with mental or physical disabilities who were specially funded in a provincial program (PD), all 102 individuals with disabilities (TD) including those 51 who were funded in the special program and those 51 who had not been funded, classification according to gender, Aboriginals, and intrafamilial or extrafamilial abuse. Table 2 gives frequencies (percentages in parenthesis) for the items defining **specific disability or handicap**. The table is broken down to show the frequency of each item for the entire sample (452), for the 102 individuals who had disabilities, and for the subgroups within (51 in program and 51 not in the program).

One fifth of the sample population (20.8%) have some level of handicap, whereas three fourths of the sample reported no handicap of any kind (77.4%). A total of 146 disability responses were calculated for the 102 files of clients with disabilities. The mean number of disabilities is 1.4 per disabled person as some clients have more than one disability. The proportion of mental disabilities to physical disabilities within that subgroup was 4 to1 (81% mental disabilities and 19% physical disabilities).

Table 2

VICTIM DEMOGRAPHICS
Frequencies for Specific Disability

Disability Specified	%age of 102 with Disability	51 Special Program	51 No Program	%age of 452 Sample
Developmentally delayed (IQ <70)	41 (40.2)	32 (31.4)	9 (8.8)	9.1
Borderline/Low Average Intellect (IQ 70-89)	41(40.2)	14 (13.7)	27 (26.5)	9.1
Neurological impairment	13 (12.7)	11 (10.8)	2 (2)	2.9
Attention deficit with/without hyperactivity ADHD/ADD	10 (9.8)	2 (2)	8 (7.8)	2.2
Auditory handicap	8 (7.8)	4 (3.9)	4 (3.9)	1.8
Fetal alcohol syndrome/effect FAS/FAE	7 (6.9)	3 (2.9)	4 (3.9)	1.5
Psychological maladjustment	5 (4.9)	4 (3.9)	1 (1)	1.1
Visual handicap	4 (3.9)	1 (1)	3 (5.9)	.9
Mobility problems	4 (3.9)	3 (2.9)	1 (1)	.9
Autistic behavior	4 (3.9)	4 (3.9)	0	.9
Learning disabled (LD)	3 (2.9)	3 (2.9)	0	.7
Unspecified	6 (5.9)	0	0	1.3
Total	146			

The sample can also be broken into special population groups by gender. Overall, females comprised three fourths (74.5%) of the sample. The proportion was not as skewed in the 102 disabled population, (TD) but females still outnumbered males by a 2 to1 margin. The proportion of females to males in the Aboriginal population was 3 to1. The results are shown in Table 3.

Table 3

VICTIM DEMOGRAPHICS

Gender Percentages of Specific Populations in Sample

Sample Populations	Size of N	MALES		FEMALES	
		Frequency	Percentage	Frequency	Percentage
Total Population	452	115	25.5	337	74.5
Total Disabled	102	33	32.4	69	67.6
Aboriginal Peoples	60	15	25	45	75

All but 68 of the files contained information on the victims' ethnic background. This could be another potential target group. Proportions for the potential special populations within the sample are shown in Figure 2. The categories for target groups are not mutually exclusive as an individual could be disabled and Caucasian. Of the 486 responses, two thirds (63.4%) fall into the North American Caucasian category, approximately one eighth (12.3 %) are Aboriginal, one tenth (10.5 %) are disabled and specially funded, another one tenth (10.5%) are more mildly disabled and not in the special program, and the remaining 3.3% is made up of groups whose numbers do not warrant investigation as target groups.

Figure 2 Potential Target Groups From VCSAS Sample

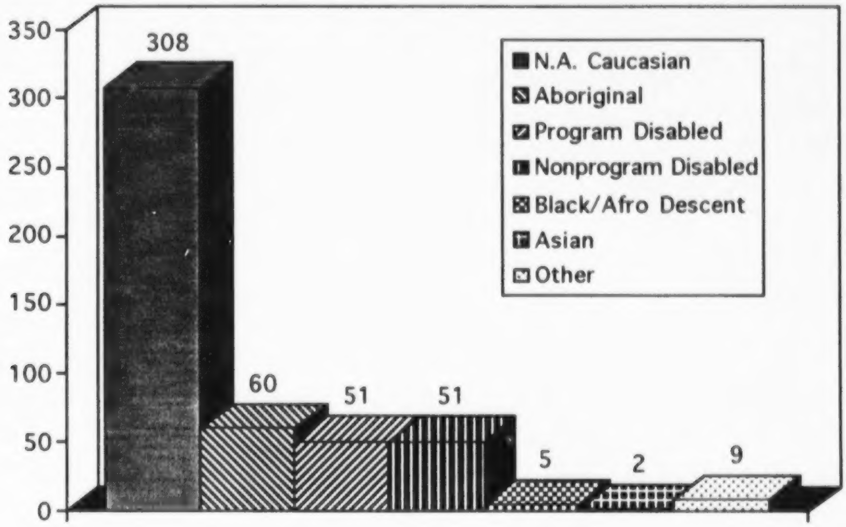

Table 4

VICTIM DEMOGRAPHICS
Referral Source

Referral Source	Frequency	%age of 416
Child Welfare	200	48.1
Professional/Community Agency	82	19.7
Police - Victim Assistance Plan	66	15.9
Parent	43	10.3
mother		10.1
father		.2
Self	15	3.6
School	10	2.4
Unknown	36	
Total	452	

* Valid percentages are based on 92% of the sample.

There are nine items defining the construct **referral source**. Three items that received no response were referrals from the church, medical professional, and other. Percentages for the six items that received a response are shown in Table 4. There was no information on referral source in 36 files. Therefore, valid percentages are given for 416 victims or 92% of the files.

It can be seen that the vast majority of known referrals (86.1%) came from professionals within the community who respond to the child's welfare. Only 13.9% come directly from either the victim or the parent, with mothers in the overwhelming majority.

There was no information in 101 files or 22.3 % of the sample on the **region of residence at time of referral**. Of the 351 known localities, all of them were from British Columbia. As would be expected, most of the victims came from Vancouver Island (340 or 96.9%), with 11 or 3.1% in the interior of British Columbia. Regarding the **region of residence at time of the abuse**, no information was found in 108 files (23.9% of the sample), but 205 (59.6%) lived on Vancouver Island, 96 (27.9) were from the interior of B.C., 34 (9.9%) were from another region in Canada, and 9 (2.6%) wre from outside of Canada. Although SAIR provides space for the entry of specific regions, there was not enough information in the files to warrant additional categories for research.

As shown in Table 5, the mean **number of offenders** per victim was 1.53. Almost three fourths (72%) of the victims disclosed one offender, and more than one fourth had two or more offenders. The greatest number of offenders per victim was coded as 10 or more. This item received one response. No information was found in 37 files. Rather than assuming each of the 37 victims had only one offender, valid percentages were obtained without these files (i.e., on 81.8% of the file sample).

Table 5

VICTIM DEMOGRAPHICS
Number of Offenders Per Victim

Number of Offenders	Frequency	%age of 415
1	299	72
2	67	16.1
3	27	6.5
4	9	2.2
5	6	1.4
6	1	.2
7	3	.7
8	1	.2
9	1	.2
10 or more	1	.2
unknown	37	
Total	452	

* Valid percentages are based on 91.8% of the sample.

There were various sample sizes for constructs concerned with the onset, termination, and duration of abuse. The frequency of responses to **age of the first recalled sexual abuse occurrence** was 396 or 87.6% of the sample. The mean age was 6.89 years, standard deviation (SD) was 4.93, range (1-40). The frequency of response for mean **age of the latest sexual abuse occurrence** was 384 or 85% of the sample. The mean age was 9.52 years, SD (5.94), range (1-45). The frequency for **current age of the client when in counselling** was 449 or 99.3% of the sample. The mean age was 12.26 years, SD (7.79), range (2-60). Table 6 also shows the means for these variables for the 102 disabled (TD) and Aboriginal populations .

Table 6

VICTIM DEMOGRAPHICS
Duration of Sexual Abuse Prior to Counselling

Event on SA Trauma Continuum	Mean Age in Years of Sample (*n*=452)	Mean Age in Years of TD (*n*=102)	Mean Age in Years Aboriginal (*n*=60)
Duration of Abuse			
* Last recalled sexual abuse incident	9.52	12.11	10.45
* First recalled sexual abuse incident	6.89	8.84	7
Duration	[2.63]	[3.27]	[3.45]
Time Span: SA to Counselling			
* Age client in counselling at VCSAS	12.26	15.41	12.63
Time from last SA incident to counselling	[2.74]	[3.3]	2.18
Time from first SA incident to counselling	[5.37]	[6.57]	[5.63]

* Mean age of first recalled incident based on 87.6% of sample.

* Mean age of last recalled incident based on 85% of sample.

* Mean age of current age in counselling based on 99.3 % of sample.

Table 6 shows the average number of years a victim experiences SA prior to receiving counselling (i.e., the mean number of years for the duration of abuse and the time spans from both the time the abuse started until it terminated to the time of counselling). In order to calculate this information, actual items (i.e., those with an asterix) were used to calculate nonexisting "items" from SAIR (i.e., those without an asterix). The calculated means are in brackets. Since each item in SAIR is independently determined by the number of responses for that item, actual percentages of the files used to determine the item means are provided at the bottom of Table 6.

Table 6 also provides an example of a comparison among possible target samples within the clientele at VCSAS. There are three target samples used in this table regarding duration of SA prior to counselling: the entire sample of 452 files, the entire sample of 102 disabled (i.e., those within and without the specially funded program), and 60 Aboriginal individuals. It can be seen that the mean **age of onset of SA** for the 102 population with disabilities is almost 2 years later than for the whole sample (8.84 - 6.89 =1.95 years) and for the Aboriginal victims (8.84 - 7 = 1.84 years). Likewise, the mean age for the **termination of the SA** for the population with disabilities is also later than the population without disabilties (12.11 - 9.52 = 2.59 years) and the Native sample (12.11 - 10.45 = 1.66 years). The **duration of abuse** is about 1 year longer for both the disabled group (3.27 - 2.63 = .64 years) and the Native group (3.45 - 2.63 = .82 years) than for the large sample. The disabled tend to **receive counselling** at a mean age approximately 3 years older than other victims in the comparable samples (15.41 - 12.26 = 3.15 years for the whole sample and 15.41 - 12.63 = 2.78 years for Aboriginals).

The population with disabilities also show a greater mean number of years from both the onset and termination of SA to the time of counselling than do others in the sample of files. The onset of SA for persons with disabilities is approximately 1 year later than the onset of the whole sample (6.57 - 5.37 = 1.2 years) and for the Native population within the sample (6.57 - 5.63 = .94 years). The termination of abuse is also approximately 6 months later for the disabled than the whole sample (3.3 - 2.74 = .56 years) and 1 year later than the Native population (3.3 - 2.18 = 1.12 years). If one considers trauma to have occurred from the initial incident of CSA until the victim receives counselling, then the mean number of years the victim did not receive outside support is approximately 1 year greater for the population with disabilities (6.57 years) than for the Native population (5.63 years) and the entire sample (5.37 years).

As shown in Table 7, there are seven items for the construct **reason abuse terminated**, and all items received responses. There was no information on this construct in 206 files, therefore, valid percentages are given for 54.2% of the sample of files. Of the items that had a response, one fourth (25.6%) indicated a direct disclosure from the victim or another person which led to the termination of the abuse. One third (28.5%) responded to the item victim moved or avoided offender, one fourth (19.9%) of the response indicated the SA was terminated by legal or professional intervention for child welfare, the offender moved or was removed from his or her position occurred for15 percent of the items, and offender lost interest received one tenth (11%) of the repsonse.

Table 7

VICTIM DEMOGRAPHICS
Reason Sexual Abuse Terminated

Reason the SA Terminated	Frequency	%age of *n*=246
Victim moved away or avoided offender	70	28.5
Victim or someone else discovered or disclosed the SA	63	25.6
Legal/professional intervention for child welfare	49	19.9
Offender moved away or was removed from position	37	15
Offender lost interest	27	11
Unknown	206	
Total	452	

* Valid percentages are given for 54.4% of the sample of files.

As indicated in Table 8, the construct **discovery or disclosure situation** has 10 items and all have responses. All but 50 files contained information on this construct allowing valid percentages to be calculated for 88.9% of the sample of files. Table 8 shows that 252 victims (62.7%) disclosed their abuse prior to counselling, and 46 disclosed in counselling (11.4%); but about one fourth of the victims (104 or 25.9 %) never disclosed the abuse directly by themselves prior to counselling. Instead, it was discovered or reported by someone else.

Table 8

VICTIM DEMOGRAPHICS
Disclosure or Discovery Situation

Disclosure/Discovery Situation	Frequency	%age of sample (*n*=402)
Victim told parent or parent substitute	147	36.6
Victim's "acting out" led to disclosure	48	11.9
Victim disclosed in counselling	46	11.4
Victim told another family member or friend	38	9.5
Someone else told on or for victim	38	9.5
Victim told a professional (not in counselling)	36	9
Victim told staff member at school	31	7.7
Medical or physical evidence	10	2.5
Offender and victim discovered in sexual act	8	2
Unknown	50	
Total	452	

* Valid percentages are calculated for 88.9% of the sample of files.

The valid percentages for items under **number of siblings** is based on the response from 344 files (76.1%). Approximately half of the victims had biological brothers (51%) and half had biological sisters (48%). Almost one third (29%) of the male victims and one fourth (23%) of the female victims came from blended families (i.e., have step or half siblings): half brothers (21%), half sisters (15%), stepbrothers (8%), stepsisters (8%). Foster siblings were found in 4 percent of the families.

The files contained information for **birth order of victim** in 357 cases or 79 percent of the file sample. The eldest child category had the most responses (198 or 55.5%), followed by the youngest child (110 or 30.8%), and finally the middle child (49 or 13.7%).

The **biological parents' relationship status during the abuse** was found for 364 victims or 80.5 percent of the sample.

Approximately one half (53.3%) of the CSA cases occurred in the home where no stable mate was acknowledged, and one half (46.7) occurred in situations where the parents were married or living in a commonlaw relationship. Results for this construct and for the **mothers' relationship status during client's counselling** can be seen in Table 9. The actual number of reponses to this last construct was 343. Therefore, valid percentages are shown for 75.9 percent of the sample.

Table 9

FAMILY DEMOGRAPHICS
Parents Relationship Status During and Following the CSA

Biological Parents' Relationship During the Abuse	Frequency	%age of sample (*n*=364)
Married	148	40.7
Divorced	95	26.1
Separated	75	20.6
Single	24	6.6
Commonlaw	22	6
Unknown	88	
Total	452	

Mothers' Relationship Status During Client's Counselling	Frequency	%age of sample (*n*=343)
Married	126	36.7
Single	100	29.2
Commonlaw	60	17.5
Separated	43	12.5
Divorced	14	4.1
Unknown	109	
Total	452	

* Valid percentages based on 80.5% of sample for construct during the abuse
* Valid percentages based on 75.9% of sample for construct during counselling

Table 9 shows the proportion of both single and commonlaw mothers as dramatically increasing from the time the abuse occurred to the time of the child's counselling: (single 6.6% to 29.2% and commonlaw 6% to 17.5%). Frequencies in the married and separated categories are similar over time: (Married 40.7% to 36.7%), while the divorce category shows a dramatic decrease over time (26.1% to 4.1%).

Response to **mother's relationship status during counselling in relation to the child's biological father** was found for 171 cases or 32.5 percent of the sample. Mixed results indicate one half (90 or 52.6%) have a different mate and about one half (81 or 47.4%) remain with the same mate. Response to **serial monogamy** was found for 110 cases or 24.3% of the sample. Of the one fourth of the sample that provided a response to this item, the vast majority of mothers (91.8%) had three or more commonlaw or marriages partners. This item was not recorded for males in the original SAIR used in Phase Two of the data collection process because there was little information on this item in the files. However, it is now part of the revised version of SAIR.

The last variable in part A of SAIR asked whether **satanic or ritual cult abuse is suspected by others or alleged by the victim**. The response was positive in eight cases or for 1.8 percent of the sample.

The purpose of reporting frequency counts is to determine whether SAIR items reflect a degree of construct validity by comparing the findings with convergent and divergent findings in the literature. Implications for some of the findings from Part A of SAIR are discussed in Chapter Five of this thesis.

HISTORY OF ABUSE IN THE FAMILY GENOGRAM
(Frequencies for Part B of SAIR)

Part B of SAIR is concerned with the **history of any type of abuse in the family genogram.** It provides the opportunity to obtain a great deal of information in a very efficient manner. The code and grid system of Part B was explained in Chapter Three. A brief reminder of how the code and grid system functions is provided: There are two grids in conjunction with a 13 point code. The code is concerned with the primary victim (i.e., the client with the file at VCSAS), and his or her relationship to someone listed in 12 items of choice (e.g., 0 = no offender information; 1 = father; 2 = stepfather or father substitute; 3 = mother; 4 = stepmother or mother substitiute; 5 = grandfather or grandfather substitute).

The first grid in Part B of SAIR is used with the relationship code just described. The grid has six columns, two columns (offender and victim) are subsumed under the heading **Relationship of Offender and Victim** and four columns fall under the heading **Type of Abuse** (sexual, physical, emotional, neglect). It is crucial to fill in the grid using the code as related to the primary victim. An example can be used as a reminder: The file belongs to a child victim of SA who attends counselling. In the course of counselling it is discovered that the child's mother is also a victim of incest by her father and neglect by her mother. This scenario fits the intergenerational hypothesis that states the mother is too overwhelmed and unable to provide the protection her daughter needs and, consciously or unconsciously, contributes to the perpetuation of intergenerational abuse by selecting a mate who sexually abuses the child.

Using the code for Part B in SAIR, the number 5 (grandfather from the relationship code) would be placed in the offender column and a 3 (mother from the relationship code) would be placed in the victim column. A tick would be placed under sexual abuse. On the next line, a 6 (grandmother) would be placed in the offender column and a 3 (mother) would be placed in the victim column. A tick would be placed under neglect.

A second grid of two columns for substance abuse (alcohol and drugs) can also be used with this code. For example, if both grandparents in the above scenario abused alcohol, then a 5 and a 6 would be placed in the alcohol column. If the mother's sister currently abuses drugs, an 8 (aunt) would be placed in the drugs column. This type of abuse is called "historical" abuse to distinguish it from the primary victim's sexual abuse.

There were 344 files that contributed information about 1,433 incidents of any type of historical abuse. Put in another way, three fourths (76.1%) of the victims attending VCSAS have a history of some type of abuse in their family map. Roughly two thirds of the historical abuse offenders whose gender was reported were males (68.4%) and one third were females (31.6%). Approximately one fifth (22.7%) of the victims' fathers, as well as a similar proportion of their grandfathers (20.5%) were perpetrators of PA. Taken together, mothers and grandmothers comprise one fourth (25.5%) of the historical offenders. Other male relatives comprise approximately one eighth of the sample (12.2) and other female relatives (2.6%). To explain these categories further, Tables 10 through 15 show the offending "historical relative" and any or all of the six types of abuse he or she perpetrated on the victim.

The number of positive responses for **offender of historical physical abuse (PA)** was 510. This represents 35.6% of the 1433 recorded incidents of historical abuse, which means that approximately one third of the victims who reported genogram abuse had PA within their family.

Table 10 shows that roughly three fourths of the historical PA offenders whose gender was reported were males (73.3%), and one fifth were females (20.7%). It also shows that approximately one third (33.1%) of the victims' fathers as well as one fourth of their grandfathers (27.1%) were perpetrators of PA.

Table 10

FAMILY GENOGRAM HISTORY
Offender of Historical Physical Abuse

Relationship of Offender to Victim	Frequency	%age of PA (*n*=510)
Father	169	33.1
Grandfather or grandfather substitute	138	27.1
Mother	62	12.2
Other male relatives (brother, uncle, cousin, stepbrother)	42	8.2
Grandmother or grandmother substitute	33	6.5
Stepfather or father substitute	25	4.9
Unknown offender	19	3.1
Non-relative in a position of trust or authority (foster parents, parent's mate, neighbor, priest)	12	2.4
Other female relatives (aunt, sister, cousin, stepsister)	7	1.4
Stepmother or mother substitute	3	.6
Unknown	923	
Total	1433	

* Valid percentages are based on 76.1% of the sample of files.

Table 11

FAMILY GENOGRAM HISTORY
Offender of Historical Sexual Abuse

Relationship of Offender to Victim	Frequency	%age of PA (N=431)
Other male relatives (brother, uncle, cousin, stepbrother)	118	27.4
Grandfather or grandfather substitute	110	25.5
Unknown offender	72	16.7
Father	52	12.1
Non-relative in a position of trust or authority (foster parents, parent's mate, neighbor, priest)	37	8.6
Stepfather or father substitute	25	5.8
Grandmother or grandmother substitute	8	1.9
Other female relatives (aunt, sister, cousin, stepsister)	5	1.2
Mother	2	.5
Stepmother or mother substitute	2	.5
Unknown	1002	
Total	1433	

* Valid percentages are based on 76.1% of the sample of files.

The number of positive responses for **offender of historical sexual abuse (SA)** was 431. This represents 30.1% of the 1433 recorded incidents of historical abuse, which means that approximately one third of the victims who reported genogram abuse had SA within their family.

Table 11 shows that roughly three fourths of the historical SA offenders whose gender was reported were males (70.8%), and one twentieth were females (4.1%). It also shows that approximately one fourth (27.4%) of the victims' other male relatives as well as one fourth of their grandfathers (25.4%) were perpetrators of SA. Another one eighth were the victims' fathers (12.1%).

Table 12

FAMILY GENOGRAM HISTORY
Offender of Historical Neglect

Relationship of Offender to Victim	Frequency	%age of PA (*n*=145)
Mother	68	27.3
Father	39	26.9
Grandmother or grandmother substitute	21	14.5
Grandfather or grandfather substitute	11	7.6
Other male relatives (brother, uncle, cousin, stepbrother)	2	1.4
Other relatives (gender unknown)	2	1.4
Non-relative in a position of trust or authority (foster parents, parent's mate, neighbor, priest)	1	.7
Unknown	1288	
Total	1433	

* Valid percentages are based on 76.1% of the sample of files.

The number of positive responses for **offender of historical neglect** was 145. This respresents 10.1% of the 1433 recorded incidents of historical abuse, which means that approximately one tenth of the victims who reported genogram abuse had neglect within their family.

Table 12 shows that roughly four tenths of the historical neglect offenders whose gender was reported were females (41.8%), and slightly less than four tenths were males (35.9%). It also shows that approximately one fourth (27.3%) of the victims' mothers as well as one fourth of their fathers (26.9%) were perpetrators of neglect. An additional 14.5% were grandmothers.

Table 13

FAMILY GENOGRAM HISTORY
Offender of Historical Emotional Abuse

Relationship of Offender to Victim	Frequency	%age of PA (*n*=483)
Father	141	29.2
Mother	111	23
Grandfather or grandfather substitute	97	20.1
Grandmother or grandmother substitute	58	12
Stepfather or father substitute	30	6.2
Non-relative in a position of trust or authority (foster parents, parent's mate, neighbor, priest)	9	1.9
Other female relatives (aunt, sister, cousin, stepsister)	8	1.7
Unknown offender	5	1
Stepmother or mother substitute	5	1
Unknown	950	
Total	1433	

* Valid percentages are based on 76.1% of the sample of files.

The number of positive responses for **offender of historical emotional abuse (EA)** was 483. This respresents 33.7% of the 1433 recorded incidents of historical abuse, which means that approximately one third of the victims who reported genogram abuse had EA within their family.

Table 13 shows that roughly one half of the historical EA offenders whose gender was reported were males (55.5%), and more than one third were females (37.7%). It also shows that EA was common to both the victims' parents and grandparents of both sexes, with parents representing half of the EA (52.2%) and grandparents representing almost one third of the offenders (32.1). In both these generations, the male offenders exceeded the number of females offenders.

Table 14

FAMILY GENOGRAM HISTORY
Offender of Historical Alcohol Abuse

Relationship of Offender to Victim	Frequency	%age of PA (*n*=455)
Mother	114	25.1
Grandfather or grandfather substitute	97	21.3
Father	94	20.7
Grandmother or grandmother substitute	51	11.2
Other male relatives (brother, uncle, cousin, stepbrother)	45	9.9
Stepfather or father substitute	28	6.2
Other female relatives (aunt, sister, cousin, stepsister)	16	3.5
Non-relative in a position of trust or authority (foster parents, parent's mate, neighbor, priest)	7	1.5
Stepmother or mother substitute	2	.4
Unknown offender	1	.2
Unknown	978	
Total	1433	

* Valid percentages are based on 76.1% of the sample of files.

The number of positive responses for **offender of historical alcohol abuse** was 455. This represents 31.8% of the 1433 recorded incidents of historical abuse, which means that a little less than one third of the victims who reported genogram abuse had alcoholism within their family.

Table 14 shows slightly more than half of the historical alcohol offenders whose gender was reported were males (58.1%), and two fifths were females (40.2%). It also shows that alcoholism, much like EA, runs throughout victims' parents and their grandparents categories, with almost equal frequencies among gender. Mothers comprised one fourth of the response (25.1%), and fathers and grandfathers each provided another one fifth (20% and 21.3%, respectively). Grandmothers added to more than 10% of the response.

Table 15

FAMILY GENOGRAM HISTORY
Offender of Historical Drug Abuse

Relationship of Offender to Victim	Frequency	%age of PA (*n*=126)
Mother	55	43.7
Father	30	23.8
Stepfather or father substitute	14	11.1
Other male relatives (brother, uncle, cousin, stepbrother)	10	7.9
Non-relative in a position of trust or authority (foster parents, parent's mate, neighbor, priest)	5	4
Grandfather or grandfather substitute	4	3.2
Other female relatives (aunt, sister, cousin, stepsister)	4	3.2
Grandmother or grandmother substitute	3	2.4
Stepmother or mother substitute	1	.8
Unknown	1307	
Total	1433	

* Valid percentages are based on 76.1% of the sample of files.

The number of positive responses for **offender of drug abuse** was 126. This respresents 8.8% of the 1433 recorded incidents of historical abuse, which means that less than one tenth of the victims who reported genogram abuse had drug abuse within their family.

Table 15 shows that the proportion of known male and female offences in this category was almost half and half with females (50.1%) slightly outnumbering males (46%). It also shows that approximately two fifths (43.7%) of the victims' mothers as well as one third of victims' fathers and stepfathers (34.1%) abused drugs.

Historical Victimization

The sample of 344 files (76.1%) which contained information on offending relatives could also be used to determine the client's relatives who were victims of any type of abuse (physical, sexual, emotional, and neglect). There are no possible entries for victim category in either alcohol or drug abuse as they had been previously coded as offences and determined in Tables 14 and 15.

There were 985 reported incidents of historical victimization. Approximately one fourth (26.9%) of the victims' mothers as well as 13.9% of other female relatives comprised the major proportion of reported incidents when the historical victim's gender was known (40.8%). Tables 16 through 19 are a repeat of the same variable categories by type of historical abuse except that they reveal the data for the victim of the abuse.

The number of positive responses for **victim of historical physical abuse (PA)** was 486. This represents 49.3% of the 985 recorded incidents of historical abuse which means that approximately one half of the primary victims' relatives who experienced any type of abuse were victims of PA. These victims shall be termed "historical" victims to avoid confusion with the primary victim reporting the abuse in the genogram.

Table 16

FAMILY GENOGRAM HISTORY
Victim of Historical Physical Abuse

Relationship of Victim to Offender	Frequency	%age of PA (*n*=486)
Mother	210	43.2
Unknown victim	81	16.7
Other male relatives (brother, uncle, cousin, stepbrother)	69	14.2
Other female relatives (aunt, sister, cousin, stepsister)	69	14.2
Grandmother or grandmother substitute	28	5.8
Father	19	3.9
Stepfather or father substitute	3	.6
Grandfather or grandfather substitute	3	.6
Non-relative in a position of trust or authority (foster parents, parent's mate, neighbor, priest)	1	.2
Stepmother or mother substitute	1	.2
Unknown	499	
Total	985	

* Valid percentages are based on 76.1% of the sample of files.

Table 16 shows that roughly two thirds of the historical PA victims whose gender was reported were females (63.2%), and one fifth were males (18.7%). It also shows that mothers comprise 43.2%, with other female relatives and other male relatives experiencing PA equally (14.2%).

Table 17

FAMILY GENOGRAM HISTORY
Victim of Historical Sexual Abuse

Relationship of Victim to Offender	Frequency	%age of PA (*n*=430)
Mother	191	44.4
Other female relatives (aunt, sister, cousin, stepsister)	126	29.3
Other male relatives (brother, uncle, cousin, stepbrother)	53	12.3
Unknown victim	19	4.4
Father	14	3.3
Grandmother or grandmother substitute	6	1.4
Stepfather or father substitute	5	1.2
Non-relative in a position of trust or authority (foster parents, parent's mate, neighbor, priest)	3	.7
Stepmother or mother substitute	2	.5
Unknown	555	
Total	985	

* Valid percentages are based on 76.1% of the sample of files.

The number of positive responses for **victim of historical sexual abuse** (SA) was 430. This represents 43.7% of the 985 recorded incidents of historical abuse, which means that approximately two fifths of the primary victims' relatives who experienced any type of abuse were victims of SA.

Table 16 shows that roughly three fourths of the historical SA victims whose gender was reported were females (75.6%), and one fifth were males (16.8%). It also shows that mothers comprise 44.4%, with other female relatives adding another one third (29.3%) to the proportion of victims. Other male relatives who experienced SA contributed over 10% (12.3).

Table 18

FAMILY GENOGRAM HISTORY
Victim of Historical Neglect

Relationship of Victim to Offender	Frequency	%age of PA (*n*=126)
Unknown victim	56	44.4
Mother	24	19
Other male relatives (brother, uncle, cousin, stepbrother)	20	15.9
Other female relatives (aunt, sister, cousin, stepsister)	20	15.9
Father	6	4.8
Unknown	859	
Total	985	

* Valid percentages are based on 76.1% of the sample of files.

The number of positive responses for **victim of historical neglect** was 126. This represents 12.8% of the 985 recorded incidents of historical abuse, which means that approximately one eighth of the primary victims' relatives who experienced any type of abuse were victims of neglect.

Table 18 shows that roughly one third of the historical neglect victims whose gender was reported were females (34.9%), and one fifth were males (20.7%). It also shows that mothers comprise one fifth (19%) of the victims experiencing neglect.

The number of positive responses for **victim of historical emotional abuse (EA)** was 405. This represents 41.1% of the 985 recorded incidents of historical abuse, which means that approximately two fifths of the primary victims' relatives who experienced any type of abuse were victims of EA.

Table 19 shows that a little more than half of the historical EA victims whose gender was reported were females (56.3%), and one fifth were males (21.8%). It also shows that mothers again comprise approximately two fifths of the total response (37.5%).

Table 19

FAMILY GENOGRAM HISTORY
Victim of Historical Emotional Abuse

Relationship of Victim to Offender	Frequency	%age of PA (*n*=405)
Mother	152	37.5
Unknown victim	87	21.5
Other female relatives (aunt, sister, cousin, stepsister)	61	15.1
Other male relatives (brother, uncle, cousin, stepbrother)	59	14.6
Father	27	6.7
Grandmother or grandmother substitute	15	3.7
Stepfather or father substitute	2	.5
Other relatives (gender unknown)	2	.5
Unknown	580	
Total	985	

* Valid percentages are based on 76.1% of the sample of files.

Summary of Data From Part B of SAIR

Part B of SAIR works on a code and grid system to determine the frequencies of six types of abuse (physical, sexual, emotional, neglect, alcohol, and drug) that occur within the family history. This type of abuse is termed historical abuse to distinguish it from the abuse suffered by the primary victim (i.e., the client whose file is part of the research sample).

In the sample of 452 files pulled from VCSAS, 344 files (76.1%) contained information about historical abuse. A tally of these incidents revealed 1,433 cases of offending relatives engaging in one or more of the six categories of abuse. These offenders were classified into smaller categories (e.g., father, stepmother). A further breakdown is included with some items for clarification: **other male relatives** provides brother, uncle, cousin, or stepbrother as examples. Tables 10 through 15 provide valid percentages for the relatives classified as offenders of the six types of historical abuse.

Roughly two thirds of the historical abuse offenders whose gender was reported were males (68.4%) and one third were females (31.6%). Approximately one fifth (22.7%) of the victims' fathers, as well as a similar proportion of their grandfathers (20.5%) were perpetrators of PA. Taken together, mothers and grandmothers comprise one fourth (25.5%) of the historical offenders. Other male relatives comprise approximately one eighth of the sample (12.2) and other female relatives (2.6%).

Tables 16 through 19 show the relatives of the primary client who were victims of one or more of four types of abuse (physical, sexual, emotional, and neglect). There are no possible entries for victim category in either alcohol or drug abuse as they were previously coded as offences.

There were 985 reported incidents of historical victimization in three fourths (76.1%) of the sample of files. Approximately one fourth (26.9%) of the victims' mothers as well as 13.9% of other female relatives comprised the major proportion (40.8%) of reported incidents when the historical victim's gender was known.

The purpose of reporting frequency counts is to determine whether SAIR items reflect a degree of construct validity by comparing the findings with convergent and divergent findings in the literature. Implications for these findings are discussed in Chapter Five of this thesis.

ALLEGED OFFENDER DEMOGRAPHICS AND INCIDENTS
(Frequencies for Part C of SAIR)

Novel Research Constructs

The development of SAIR took three phases which are described in Chapter Three. Many items conceived for SAIR were either too vague or too inconsistent in the literature to be reliable. For this reason, several large constructs provide the framework of SAIR. Most constructs associated with the phenomena of CSA are comprised of varying numbers of items that, when taken as a whole, define the construct in its complexity. Items that comprise choices within the construct, at at times, within themselves (e.g., sequelae items), are coded independently. Thus, the frequency of responses to each item vary for the 452 files. Therefore, it is important to note the percentage of the sample of files that provide the total from which the actual percentages are determined. This percentage is provided at the bottom of each Table in Part C.

The files contained sparse information on many of the offender variables. One reason has been discussed above (i.e., constructs are vague, inconsistent, or poorly understood in the literature). Another reason is that the information was unavailable in the files. It appears that most counsellors at VCSAS do not ask, or are unable to retrieve, information: (a) about the offender (e.g., age, education or employment); (b) details surrounding the abuse (e.g., possible patterns in time or place); (c) the reporting procedure (e.g., whether a victim made a statement, or if charges are subsequent); and (d) the outcome of the investigation (e.g., acquitted, prison term, charges dropped). Certainly, some of the clients are through with counselling and the files are closed by the time legal procedings are completed. Still, if a counsellor records these items prior to closing a file, he or she is more likely to pursue their response (e.g., contact client or court worker).

Furthermore, by asking clients questions that are commonly associated with CSA, victims may experience a sense of normalacy in that they no longer feel the abuse only happens to them. It may be helpful for the client to be guided through SAIR by a trained professional who is sensitive and aware of the possible psychological impacts in responding to SAIR items. Descretion of when to record the information during the counselling process is left up to the individual counsellor.

There were a number of logistical problems related to the reliability and validity of data collection in this study that required obtaining a large sample size. First, the sample of files represented a heterogeneous clinical population containing subgroups within the sample. Second, unavailable information in the files meant the possibility of small effect size. Therefore, some results were discarded or have to be interpreted with caution. Third, constructs were poorly defined or nonexistent in the literature requiring many SAIR items to be created in consultation with professionals. Although this process is a measure of face validity, this researcher acknowledges its limitations and recognizes the need for further research to establissh construct validity..

Frequencies for Part C of SAIR

The items in Part C of SAIR concern alleged offender demographics, information about the incidents (e.g., number of occurrences, patterns in time and place), reporting procedures, and outcome of the legal investigation. There were a total of 689 alleged offenders for the 452 victims in the sample (i.e., a mean of 1.5 offenders per victim). Broken down by **gender of offender**, there were 633 (91.9%) males and 56 (8.1%) females. There were 31 cases reported (4.5%) where the offender was known to have a **mental or physical disability** but the specific disability of the offender was seldom known and therefore was unable to be coded for statistical information. However, if this information were available, it could be coded according to the same grid used for the victim in Part A of SAIR.

Statistics for the variable **age of the offender at the time the SA began** was known for 386 or 56% of the cases: mean (23.9 years), SD (15.3), range in age offender began (3-81 years). **Age of the offender when the SA terminated** was known for 299 or 43.3% of the cases. The mean age was 27 years, SD (15.9), range in age offender stopped was 4-81 years. **Difference in age of the offender and the victim** was known for 364 or 52.8% of the cases. Mean age difference was 18.4 years, SD (15.3), range of difference in ages was 1-72 years. **Duration of abuse** was known for 393 or 57% of the cases. The mean length of time the abuse continued was 32.5 months or 2.7 years. This confirms the mean duration shown for victims in Table 6 (2.63 years). The SD was 41.6 months (3.5 years), range for the duration of time of SA was 216 months (i.e., a one time incident to 18 years).

The specific age of an offender was often difficult to obtain from the files. However, many files contained enough general information about the offender to determine his or her age grouping (e.g., an offender attending high school could be categorized as an adolescent). In this way, much of the lost information regarding the age of offender could be made available. Therefore, **age of the offender when the abuse began** was also broken down into three general categories to represent **child** (birth to 12), **adolescent** (13 to 19), and **adult** (20 years or older). Of the 689 cases reported in the files, almost three fourths 477 (69.2) were adults, 96 (14%) were teens, and 116 (16.8%) were in the child category. **Age of the offender when the abuse terminated** was adult 396 (57.5%), teen 173 (25.1%), and child 120 (17.4%).

Duration of the SA was calculated using the mean number of months. Three target samples within the sample were compared. The mean number of months for the 60 Native clients was 13.2, and it was 19.5 for the remaining 392 individuals who were not Aboriginal. This indicates that the non-Native sample tended to experience SA about 6 months longer than the Aboriginal victims. The mean duration of SA for the 102 individuals who had a disabilitiy was 33 months and 32.3 months for the 350 clients without disabilities, which is a very even split. Separate chi square analyses found no differences in the distribution of these means for either type of grouping.

Table 20 highlights ten constructs in Part C of SAIR whose valid percentages are based on less than half (345 or 50%) of the sample of 689 offenders.

Table 20

ALLEGED OFFENDER DEMOGRAPHICS AND INCIDENTS
Constructs Whose Percentages are Based on Less Than Half the Sample of Offenders

Variable	Frequency of response	%age of offenders (*n*=689)
Criminal charges laid	344	49.9
Age of offender when SA terminated	299	43.3
Outcome of investigation	271	39.3
Education or occupation of offender	134	19.4
Additional abuse tactics used by offender	131	19
Offender has addictions	86	12.5
Patterns of abuse	244	35.4
Time patterns	65	9.4
Place patterns	99	14.4
Other patterns	120	17.4

Table 20 shows that information on possible abuse patterns should be interpreted cautiously because it is based on only one third (35.4%) of the total population of 689 offenders. However, there were still 244 reported patterns of offenders that provided substantial data to analyze and interpret. The other constructs in this chart will also be interpreted in this chapter, although somewhat cautiously. The purpose of including these items in the analysis is to show that the items are workable statistically. Although some constructs in SAIR are little known and have been poorly defined to date, they can provide valuable information and are included in SAIR to record this information in the future.

There was no information in 555 cases for the variable listed as **education or occupation of the offender** leaving 134 cases (19.4% of the file sample) from which to base the valid percentages presented in Table 21.

Table 21

ALLEGED OFFENDER DEMOGRAPHICS AND INCIDENTS
Education or Occupation of Offender

Education or Occupation of Offender	Frequency	%age of offenders (*n*=134)
Student	67	50
Blue collar/laborer	38	28.4
Professional or in the military	17	12.7
Unemployed	8	6
Preschool	4	3
Unknown	555	
Total	**689**	

*Valid percentages are based on 19.4% of 689 offenders.

Table 21 must be interpreted cautiously because it is based on one fifth of the sample of offenders. The only category which received no response for the above construct was that of **homemaker or caregiver**. Of those offenders recorded, one half (50%) were students themselves. This probably reflects that the education of a young offender is more likely to be known and recorded in the client's file than the education or occupation of an older offender, rather than indicate an actual increased incidence of younger over older offenders. This hypothesis is verifed by response to items related to the age of the offender (as noted previously) where means calculated for the **age of offender when the abuse began and terminated** showed the vast majority of offenders to be classified as **adults** (69.2% and 57.5%, respectively) whereas the proportion of **adolescents** was found to be 14 and 25.1 percent, respectively.

Approximately one third (35.4%) of the sample provided responses to items concerned with the construct **patterns of abuse**. There were 244 files which contained information on patterns relating to **time**, **place**, or **other** patterns. These smaller constructs were further broken down into items providing examples of plausible definitions for time and place (a blank item allows for recording a situation other than given items). Of the 65 cases reporting patterns of time, approximately one fourth (17 or 26.1%) of the SA cases occurred while the victim was on holidays or during a special occasion such as a family visit to relatives. One fifth of the respondents indicated the abuse happened during babysitting (14 or 21.5%), and one fifth responded that the abuse took place after school or on the weekends (12 or 18.5%). Equal proportions were indicated for the abuse occurring at bedtime (7 or 10.8%) and when the victims' or offenders' parents were away from home (7 or 10.8%). Approximately 10% (6 or 9.2%) reported the abuse took place during either school or daycare hours. Finally, 2 victims (3.1%) reported the SA happened in conjunction with a party attended by either the victim or the offender.

Patterns surrounding the **place** of abuse were indicated in 98 cases (14.2% of the files). Valid percentages based on this limited response sample revealed the following trends: Approximately one fourth (24 or 24.5%) of the SA incidents occurred in the victims' homes, 16 (16.3%) of the abuse incidents occurred in an educational setting, 13 (13.3%) occurred in an institutionalized setting such as home care for the disabled, 12 (12.2%) occurred in a park, 10 (10.2%) occurred in a bedroom, 8 (8.2%) incidents occurred in a bath or hot tub, 4 (4.1%) occurred in a vehicle, 3 (3.1%) occurred at public facilities such as a swimming pool or gym, and 2 (2%) occurred in a church or some religiously affiliated building.

There were 120 response patterns (17.4% of all offenders) classified under **other**: 66 reports (55%) deal with abuse occurring in a medical setting , 29 (24.2%) concern the offender and excessive religious beliefs and routines, 13 (10.8%) involve some connection (other than medical or religious) to an institution, 10 (8.3%) involve pornography, and 2 (1.7%) able to identify grooming as the process. This last percentage is expected to be low as very few counsellors use the term *grooming* , although some may be aware of the process.

Aside from sexual abuse there are other types of abuse perpetrated on the victim: physical (PA), emotional (EA), neglect, or all of these in conjunction and concurrent with SA. Response to **additional abuse tactics by alleged offender** was found 131 times or for one fifth (19%) of all offenders. Actual percentages based on this one fifth indicate one third of offenders 48 (36.6%) employ all types of abuse, one third (43 or 32.8%) use emotional and verbal abuse, three tenths (38 or 29%) use physical abuse, and a minimal amount (2 or 1.5%) are neglectful.

The **relationship status of the alleged offender during the abuse** was known for 290 instances (42.1% of the file sample). Valid percentages reveal approximately one half were single (49.7%), and close to one half (45.8%) were married or living commonlaw. The results are summarized in Table 22.

Table 22

ALLEGED OFFENDER DEMOGRAPHICS AND INCIDENTS
Relationship Status of Offender

Relationship Status	Frequency	%age of offenders (*n*=290)
Single	144	49.7
Married	93	32
Commonlaw	40	13.8
Separated	7	2.4
Divorced	6	2.1
Unknown	399	
Total	689	

* Valid percentages are based on 42.1% of 689 offenders.

No indication was found in any files regarding the **offenders' sexual orientation** (i.e., heterosexual or homosexual). Therefore, it can only be assumed that the above responses primarily relate to heterosexual relationships.

The **relationship of alleged offender and victim** was coded for each case using the same relationship code from Part B of SAIR. Most of the files (98.8%) contained this information. There were 681 separate cases noted. Results are shown in Table 23.

Table 23

ALLEGED OFFENDER DEMOGRAPHICS AND INCIDENTS
Relationship of Offender and Victim

Relationship	Frequency	%age of offenders (*n*=681)
Known & trusted acquaintances (neighbor, family friend, boy/girlfriend, peer, parent's mate)	273	40.1
Father	89	13.1
Other male relatives (uncle brother. cousin, stepbrother)	77	11.3
Hired position of trust (teachers, daycare workers, babysitters)	57	8.4
Stepfather or father substitute	48	7
Residential hired position of trust (caregivers, respite workers, foster parents, foster siblings)	36	5.3
Stranger	31	4.6
Grandparents or grandparent substitute	24	3.5
Other relatives (gender unknown)	22	3.3
Other female relatives (aunt, sister, cousin, stepsister)	16	2.3
Mother	7	1
Stepmother or stepmother substitute	1	.1
No information	8	
Total	689	100

* Valid percentages based on 98.8% of 689 offenders.

Although the split between intrafamilial and extrafamilial was fairly even, there were more offenders classified from outside the family than from inside the family. If the victim's mother had a commonlaw mate for 2 or more years, the mate was classified as a father substitute, rather than simply an outsider to the family. The frequencies for the entire range of offenders for this variable were 284 intrafamilial (41.2%) and 397 extrafamilial (57.6%).

Table 24

ALLEGED OFFENDER DEMOGRAPHICS AND INCIDENTS
Frequencies for Categories of Intrafamilial Abuse

Relationship of Offender and Victim	Frequency	%age of (*n*=284)
Father	89	31.3
Other male relatives (uncle, brother, cousin, stepbrother)	77	27
Stepfather or father substitute	48	16.9
Grandparents or grandparent substitute	24	8.5
Other relatives (gender unknown)	22	7.7
Other female relatives (aunt, sister, cousin, stepsister)	16	5.6
Mother	7	2.5
Stepmother or mother substitute	1	.4
No information	8	
Extrafamilial relationship	397	
Total	689	

* Valid percentages based on 41.2% of sample categorized as intrafamilial.

As shown in Table 24, fathers, other male relatives, and stepfathers or father substitutes make up three fourths (75.2%) of the offenders who are related to their victims. In contrast, females represent a small proportion (8.5%) of those offenders whose gender was known.

Table 25

ALLEGED OFFENDER DEMOGRAPHICS AND INCIDENTS
Categories of Extrafamilial Abuse

Relationship of Offender and Victim	Frequency	%age of (*n*=397)
Known and trusted acquaintances (neighbor, family friend, boy/girlfriend, peer, parent's mate)	273	68.8
Hired position of trust outside of home (teachers, daycare workers, babysitters)	57	14.4
Hired positon of trust for the home (caregivers, respite workers, foster parents & their children)	36	9.1
Stranger	31	7.8
No information	8	
Intrafamilial relationship	284	
Total	689	

* Valid percentages based on 57.6% of sample categorized as extrafamilial.

Table 25 provides the breakdown of the proportions of extrafamilial abuse. Over two thirds were a known and trusted acquaintance (68.8%). Others who were in a position of authority comprise almost one fourth (3.5%). Strangers comprise less than 10%.

Results are limited regarding **addictions of alleged offender** as only 86 cases were indicated (12.5%). However, of the one eighth of the responses provided most (55 or 64%) abused alcohol. Other addictions such as gambling or solvents (24 or 27.9%), and drugs (7 or 8.1%) were also recorded.

Frequency of offence was calculated using three levels: **once, two to 10 times,** and **more than 10 times**. The frequency of offence was known for 614 cases (89.1% of the sample). Responses indicated that the vast majority of offending relationships evolve past a one time occurrence (73.3%). Results are shown in Table 26.

Table 26

ALLEGED OFFENDER DEMOGRAPHICS AND INCIDENTS
Frequency of Offence

CATEGORY OF NUMBER OF INCIDENTS	Frequency	%age of incidents (*n*=614)
Once	164	26.7
Two - 10 times	228	37.1
More than 10 times	222	36.2
Unknown	75	
Total	**689**	

* Valid percentages are based on 89.1% of 689 offenders.

The degree of intrusiveness of the sexual abuse was determined by the construct called **type of sexual abuse**. Four items define its levels. Although a victim may have experienced several levels of SA, only the highest degree of intrusiveness was recorded in coding this variable. There were 614 cases in which there was information on this variable (89.1% of the file sample). Table 26 shows that approximately one half of the responses indicate the highest degree of intrusiveness (51.2%). Four tenths (40%) of the incidents recorded intrusive SA, and less than five percent terminated with less (4.3) or least (3.6%) intrusive sexual abuse. In determining what **degree of intrusiveness** actually measures, it can be stated that 92% of the victims reported at least attempted fondling with skin-to-skin contact. Less than 10% of the cases (7.9%) involve no skin-to-skin contact.

Table 27

ALLEGED OFFENDER DEMOGRAPHICS AND INCIDENTS
Type of Sexual Abuse

Degree of Intrusiveness	Frequency	%age of incidents (*n*=644)
Very Intrusive Sexual Abuse (Completed & attempted vaginal/anal intercourse, cunnilingus, fellatio; forced or unforced)	330	51.2
Intrusive Sexual Abuse (Completed & attempted genital fondling, simulated intercourse, digital penetration; forced & unforced)	263	40
Less Intrusive Sexual Abuse (Completed & attempted acts of intentional sexual touching of clothed breasts/genitals/other body parts; forced & unforced)	28	4.3
Least Intrusive Sexual Abuse (No physical contact such as exhibitionism, obscene phone call/gesture, exposure to pornography, sexual harassment)	23	3.6
Unknown	45	
Total	689	

* Valid percentages are based on 93.5% of 689 offenders.

The last items on Part C of the SAIR concern the legal ramifications of sexual abuse. Response to **allegation of abuse** was known for 85.3 percent of the file sample. Of the 588 cases recorded almost half (272 cases or 46.3%) of the allegations came from the victim. The next highest percentage (34.5%) of allegations came from the classification of other, with 203 entries. The third category was the parent, which had 97 cases (16.5%). A small proportion (16 or 2.7%) alleged SA but no category of offender was revealed.

The construct **abuse was reported to child welfare** received a total of 562 responses (81.6% of the sample). Of the known cases, most were reported to child welfare (392 or 69.8%) and 170 (30.2%) were not reported. Data were too sparse to record **abuse was reported to the police** (e.g.,in 32 cases the abuse was reported to a professional or agency but was not reported to the police).

Response to **reason sexual abuse was not reported** to either child welfare or the police totalled 191 cases (27.7% of the file sample). This construct has five items in additon to the unknown category. Responses were not found for victim was too frightened of the consequences and victim was unable or unwilling to disclose the event(s). Responses for offender "excused" due to age or ability or circumstances received the most response, 88 cases (46.1%). Next was 68 entries (35.1%) for victim was discouraged from reporting . **Victim was not considered to be a credible witness due to age or ability** was recorded 35 times and contributed to 18.3% of the total response.

One of the constructs in Table 20 (constructs with few data entries) is **charges laid against the alleged offender**. This variable was known for 344 cases or for half (49.9%) of the recorded offenders. Of those files which provided a response, the majority reported no charges laid (199 or 57.8%). Less than half (145 or 42.2%) of the offenders were charged. Approximately one fifth (63 cases or 18.3%) still had ongoing investigations of the alleged incidents. Simply put, about one fifth of the total files (145 or 21.6%) reported charges laid by the Crown.

As indicated in Table 28, the construct **outcome of the investigation** has numerous items. Unfortunately, the files were also sparse on information for levels of this construct and revealed only 271 (39.3) cases where the outcome was already determined. Of those known cases, no responses were found for a diverted sentence category or for a category named other. The results reveal that most information about the justice process for offenders is unknown as determined through the victims' files. It also reveals that approximately one fifth (145 or 21%) of the total sample of 689 offenders are known to have received definite punitive or rehabilitative sentences (i.e., counselling, prison, probation, restraining order, and/or community service hours).

Table 28

ALLEGED OFFENDER DEMOGRAPHICS AND INCIDENTS
Outcome of Investigation

Category of Outcome of Investigation	Frequency	%age of known outcome (*n*=271)
Charges dropped due to insufficient evidence	87	32.1
Offender sentenced to receive counselling	52	19.2
Offender sentenced to a prison term	45	16.7
Offender sentenced to a term of probation	29	10.7
Charges dropped, victim recanted statement	21	7.7
Offender aquitted of charges	18	6.6
Offender received restraining order from victim	13	4.8
Offender required to do community service hours	6	2.2
Unknown	418	
Total	689	

* Valid percentages are based on 39.3% of 689 offenders.

Summary of Part C of SAIR

The items in Part C of SAIR concern alleged offender demographics, information about the incidents (e.g., number of occurrences, patterns in time and place), reporting procedures, and outcome of the legal investigation. There were a total of 689 offenders for the 452 victims in the sample (i.e., a mean of 1.5 offenders per victim). Some of the items in this section of SAIR provided information based on percentages that were less than half of the population of offenders alleged by the clients at VCSAS. Therefore, one must take caution in interpreting these results. The purpose of reporting frequency counts is to determine whether SAIR items reflect a degree of construct validity by comparing the findings with convergent and divergent findings in the literature. A discussion of the implications of the findings from Part B of SAIR follow in Chapter Five.

VICTIM SEQUELAE
Frequencies for Part D of SAIR

As reviewed in Chapter Two, there are numerous short- and long-term symptoms associated with sexual abuse. Chapter Three describes the generation, defining, and refinement phases of items for each of the four parts of SAIR. Part D (Victim Sequelae) is constructed of commonly reported symptoms following sexual abuse across the span of early childhood through adulthood (e.g., Asher, 1988).

These symptoms (sequelae) consist of 133 items that fall under seven major categories for convenience: (a) school or work performance, (b) personal relationships, (c) sexuality, (d) bedtime, (e) hygiene, (f) behavioral and emotional symptoms, and (g) medical or somatic complaints. Each sequelae item is assumed to be independent of another (i.e, each item was coded separately in the computer). All items within a grouping (A, B, C, D, E, F, G) are also assumed to be loosely connected although no formal item analysis was undertaken for this thesis. That research on SAIR would be most welcomed in the future.

For the purposes of this study, only those symptoms that were present at the time of counselling were recorded. This was in an effort to maintain some dimension of consistency in recording sequelae. Although many of the victims had more than one offender, there is only one sequelae record for each victim. Frequencies and percentages were tabulated for each sequelae item for the entire sample of 452 files. Results show that all but five of the 452 files (98.9% of the sample) recorded one or more sequelae, the mean number of sequelae per victim was 15, the median was 13, and the range in number of sequelae for victim was 0 to 69. Table 29 provides the frequencies of response for all files recording one or more sequelae according to each of the seven sequelae groups.

Table 29

VICTIM SEQUELAE
Frequency of Victims Responding to One or More Items Within Seven Groups of Sequelae

Group of Sequelae	Frequency	%age (*n*=452)
A: School or Work Performance	251	55.5
B: Personal Relationships	360	79.6
C: Sexuality	271	60
D: Bedtime	222	49.1
E: Hygiene	75	16.6
F: Behavioral and Emotional Response	421	93.1
G: Medical or Somatic complaints	133	29.4
No Sequelae	5	1.1

As shown in Table 29, almost all (421 or 93.1%) victims had some behavioral or emotional response to their SA. Over three fourths (360 or 79.6%) experienced problems with personal relationships, more than half had problems with sexuality (271 or 60%) or revealed a change in school or work attitude and performance (251 or 55.5). Half the sample (222 or 49.1%) indicated symptoms surrounding bedtime, and three tenths (133 or 29.4%) had medical or somatic complaints. Difficulties with hygiene occurred for 75 victims (16.6%). Five individuals appeared to have no sequelae (1.1%).

Response to sequelae items are grouped from the highest to lowest frequency for each group and can be seen in Tables 30 through 41.

Table 30

VICTIM SEQUELAE
School/Work/Social Activities

Sequelae Item for Group A	Frequency	%age (n=452)
Has difficulty concentrating or staying on task	134	29.6
Avoids school/work/social responsibilities	95	21
Refuses to participate in some school/work/social activities	79	17.5
Shows sudden decline in school/work/social performance	68	15
Extremely demanding or withdrawn at school, work, or in socially related activities	47	10.4
Sexualized or bizarre art work or stories which depict themes of sexually abusive behavior (e.g., body proportions skewed, death wishes)	27	6
Extremely withdrawn at school/work/socially related activities	23	5.1
Extremely demanding at school/work/socially related activities	22	4.9
Unwillingness to undress for gym or participate in physical education activities	18	4
Overly responsible: Insists on attending school/work/social activities even when ill	18	4

Table 30 shows that almost one third of the victims (29.6%) had **difficulty concentrating** following their abuse. One fifth (21%) tended to withdraw and **avoid personal responsibilities** as a way of coping. Almost one fifth (17.5%) **refused to participate in regular daily activities.**

Table 31

VICTIM SEQUELAE
Personal Relationships

Sequelae Item for Group B	Frequency	%age (n=452)
Displays dominant/aggressive behavior toward others	196	43.4
Regularly shows inappropriate emotional response to situations	150	33.2
Inability to establish trusting close personal relationships	133	29.4
Is very shy or withdrawn: Avoids peers or men or women (circle)	116	25.7
peers	13	2.9
men	35	7.7
women	10	2.2
Has few friends	109	24.1
Is easily led or influenced/tries hard to please others by others	86	19
Role reversal/enmeshment with mother or father (circle one)	66	14.6
Repeats a pattern of engaging in abusive relationships	45	10

Table 31 shows a great number of victims had difficulty with personal relationships following their sexual abuse in that no item received less than a 10% response. The most common symptom involves **anger and aggression towards others** (43.4%). The next highest frequency was **inappropriate emotional response** (33.2%).

Table 32

VICTIM SEQUELAE
Sexuality

Sequelae Item for Group C	Frequency	%age (*n*=452)
Approaches strangers inappropriately/poor sense of personal safety	97	21.5
Touches adults/children/animals excessively or inappropriately (Circle)	95	21
Touches adults	16	3.5
Touches children	67	14.8
Touches animals	6	1.3
Has difficulty distinguishing between affection and sexual encounters	89	19.7
Is sexually promiscuous or has knowledge of sexual activity inappropriate for age level	66	14.6
Initiates "sexual games" with adults and/or children	65	14.4
sexual games with adults	6	1.3
sexual games with children	45	10
Uses sexuality for approval seeking from adults or children	58	12.8
Verbalizes inapppropriate "sexual" remarks, comments, jokes	54	11.9
Experiences sexual dysfunction (e.g., impotency, fear of sexual intimacy, dislikes sex)	51	11.3
Presents as a "little adult	49	10.8
Touches self excessively or inappropriately (e.g., masturbates excessively for age level, continuously fondles erogoneous zones)	49	10.8
Preoccupied with sexual thoughts or fantasies (e.g., pornography, overly interested in doll's genitals during play)	37	8.2
Dresses inappropriately: seductively or layering (Circle)	29	6.4
Dresses seductively	14	3.1
Covers body in layers of clothing	10	2.2
Has little or no age appropriate sexual knowledge	24	5.3
Shows confusion regarding his/her sexual orientation	15	3.3

Table 32 displays problems with the victims' sexual awareness and adjustment following sexual abuse. The three largest items each received about one fifth of the responses, and all have a connection with a poor sense of personal boundaries. These are **approaching strangers inappropriately** (21.5%), **touching others or animals inappropriately** (21%), and an **inability to determine the difference between affection and sexual encounters** (19.7%). This same theme is also shown in other items: **sexual promiscuity** (14.6), **initiating sexual games with others** (14.4%), and **uses sexuality to obtain approval from others** (12.8%).

Another theme that pervades this group of sequelae is that of sexual dysfunction following SA. Examples provided are **impotency or a fear or dislike of sex** (11.3%), **shows confusion regarding sexual orientation** (3.3%), and **dresses in layers to cover body** (2.2%).

It is important to note that these later items may be low due to the young age of the victims, many of whom are not yet old enough to have a sexual relationship following the abusive situation. Therefore, it is possible that these percentages of sexual dysfunction would increase if the mean age of the victims was higher.

The next group of sequelae refer to problems that occur specifically at bedtime. **Nightmares or recurring dreams** following the abuse was the most commonly endorsed item (38.1%). Almost one fifth (17.7%) expressed **generalized problems with sleep** (i.e., not able to get to sleep or to maintain sleep throughout the night). These and the frequencies of the other items in this grouping can be seen in Table 33.

Table 33

VICTIM SEQUELAE
Bedtime

Sequelae Item for Group D	Frequency	%age (*n*=452)
Has nightmares or recurring dreams on a regular basis	172	38.1
Sleep disorder (insomnia, hypersomnia, uses sedatives)	80	17.7
Avoids going to bed or refuses to sleep alone	59	13.1
Refuses to sleep in bed preferring chair, floor, couch...)	18	4
Insists on sleeping fully clothed	10	2.2
Keeps a weapon such as a club or knife close by bed	9	2

Another problem area for some victims of CSA has to do with **personal hygiene**. Although all items in this category were endorsed, the frequencies were low in comparison to most items in other groupings of sequelae. Results are shown in Table 34.

Table 34

VICTIM SEQUELAE
Hygiene

Sequelae Item for Group E	Frequency	%age (*n*=452)
Appears unkempt or dirty on a regular basis	22	4.9
Becomes agitated during bathroom or bedroom routine(s)	21	4.6
Exhibits excessive modesty surrounding bathroom or bedroom functions	17	3.8
Is immodest, uninhibited at home or in a social situation	11	2.4
Tries to "spy" on or intrudes on others in areas of privacy	8	1.8
Appears to be overly concerned with personal cleanliness/appearance	7	1.5
Excessive problems with menses (e.g., obsessive fear, fascination, poor hygiene)	2	.4

Behavioral and emotional symptoms is a vast category of items, and it is broken down into six subgroupings as seen in Tables 35 through 40.

Responses to emotional lability and/or behavioral changes (Table 35) reveal that this is a common area of sequelae following CSA, with most of the items obtaining percentages representing at least one fourth of the population. Well over one third of the victims expressed varying degrees of **depression** (31.6% and 8.2%). One fourth felt extremely **angry** (26.8% and 24.1%).

Table 35

VICTIM SEQUELAE
Emotional and/or Behavioral Lability

Sequelae Item for Group F	Frequency	%age (*n*=452)
Appears depressed on a regular basis	143	31.6
Shows a sudden behavior change	138	30.5
Expresses homicidal ideation towards (specify) ________________	121	26.8
Expresses intense anger towards (specify) ____________________	109	24.1
Periodically runs away or threatens to run away	46	10.2
Attempts suicide or has in past following abuse	37	8.2

Table 36 shows that almost one third of CSA victims appear **unusually nervous or agitated**. Many of these victims express this **fear towards some specific person** (16.5%) or **situation** (13.9%).

Table 37 shows frequencies of **eating disorders**. Taken together, they comprise almost one fifth of the entire sample. Separately, the frequencies are substantially less.

Table 36

VICTIM SEQUELAE
Fears

Sequelae Item for Group F	Frequency	%age (*n*=452)
Appears unusually nervous or anxious	134	29.6
Displays intense fear of a specific person (specify)______________________________	75	16.6
Displays intense fear in a specific situation (specify) ______________________________	63	13.9
Experiences flashbacks of abuse	44	9.7
Expresses fear about losing control and becoming abusive to self or others (Circle)	34	7.5
Experiences panic attacks	25	5.5
Displays intense fear of a specific place (specify) ______________________________	14	3.1
Has memories or fears of choking, suffocating, stuttering (Circle)	13	2.9

Table 37

VICTIM SEQUELAE
Eating Disorders

Sequelae Item for Group F	Frequency	%age (*n*=452)
Eating disorder: a change in intake of food, either increasing or descreasing following SA	80	17.7
Shows a decrease in appetite or weight loss since abuse such as a general lack of interest in food, anorexia, bulemia (Circle)	42	9.3
Shows an increase in appetite (overeating, weight gain)	23	5.1

Table 38

VICTIM SEQUELAE
Poor Self-Esteem

Sequelae Item for Group F	Frequency	%age (n=452)
Expresses an inordinate amount of shame regarding abuse	92	20.4
Expresses an inordinate amount of guilt and self-blame	86	19
Assumes "victim" role (e.g., procrastination, overly dependent on others, fear of failure)	62	13.7
Is overly passive and unassertive	60	13.3
Expresses discontent with body self image	52	11.5

Table 38 reveals that approximately one fifth of the sample experience **shame** and one fifth experience **guilt** about their experience of SA. It is interesting to note that all the items in this sequelae grouping have a response greater than 10% of the sample.

Table 39 relates to problems with dissociation. Again, an **inability to focus or maintain attention** following abuse was noted in almost one fifth of the files (18.8%). Almost one third of the victims were **unwilling or unable to discuss their feelings** about the abuse (30.8%), and 15.3% had a **flat or inappropriate affect** regarding the SA.

Table 39

VICTIM SEQUELAE
Dissociative Experiences

Sequelae Item for Group F	Frequency	%age (*n*=452)
Unwillling or unable to discuss personal feelings	139	30.8
Inability to focus/sustain attention for reasonable period since abuse	85	18.8
Flat or inappropriate affect	69	15.3
Repressed memories from childhood	59	13.1
Engages in self abuse (e.g., pulls hair or nails, scratches or cuts self)	53	11.7
Intense ego state changes	41	9.1
Tendency to withdraw into fantasy	40	8.8
Intense ego state changes with some memory loss or co-consciousness	17	3.8
Multiple personality disorder (separate & distinct parts of self each of which can be dominant to the exclusion of others)	7	1.5

The next grouping of emotional/behavioral sequelae is concerned with substance abuse. Victims at VCSAS reported abuse of **alcohol** 46 times or in 10.2 percent of the cases. Use of illicit **drugs** was reported in 36 cases (8%). **Tobacco** use was reported by 15 victims or in 3.3 percent of the cases. Again, these numbers are expected to be somewhat low due to the young age of the victims.

Table 40 shows the grouping of sequelae that are concerned with other generalized developmental problems in children who have been sexually abused. Approximately one fifth of the sample (22.6%) showed various **types of regressive behavior**. Another one fifth of the sample indicated **attention seeking behavior** by the victims (22.1%).

Table 40

VICTIM SEQUELAE
Other Developmental Problems

Sequelae Item for Group F	Frequency	%age (*n*=452)
Shows regressive behavior following abuse such as thumbsucking, enuresis, encopresis, baby talk, clingy behavior,rocking, head banging, other (Circle any or all that apply)	102	22.6
thumbsucking	9	2
enuresis	45	10
encopresis	13	2.9
baby talk	14	3.1
clingy behavior	44	9.7
Displays attention seeking/needy behaviors such as lying, exaggerating, stealing, interrupting, compliancy, defiancy, malingering, dawdling (Circle any or all that apply)	100	22.1
Makes unusual comments about home or family life	34	7.5

The last set of sequelae groupings is listed under the heading of medical or somatic complaints. Although all of the items were endorsed, all but one were responded to by less than 10% of the sample. The item that received the greatest response (16.2%) was **complaints of nervous disorders**, such as head or stomach aches. Results are shown in Table 41.

Table 41

VICTIM SEQUELAE
Medical or Somatic Complaints

Sequelae Item for Group G	Frequency	%age (*n*=452)
Complains of nervous disorders: headaches, stomach aches, skin irritations (Circle or specify other)	73	16.2
stomachaches	44	9.7
headaches	31	6.9
skin irritations	5	1.1
Appears accident/illness prone	33	7.3
Developed a sexually transmitted disease/yeast infection following abuse	21	4.6
Has pain in anal, genital, gastrointestinal or urinary area	20	4.4
Has vaginal/penile discharge, inflammation, swelling, or bladder infections	19	4.2
Pregnancy inappropriate for age or partner	15	3.3
Acts inappropriately during a medical exam	13	2.9
Complains of pain during urination	13	2.9
Has bruises, scratches, bites, or "passion" marks	12	2.7
Has injury to lips or genital area (e.g., blood stains on underwear, rash arounnd lips)	10	2.2

Summary of Part D of SAIR

Tables 30 through 41 reveal the frequencies and valid percentages for each item within the four Parts of SAIR. The number of items vary with each of the seven major groupings of sequelae, as does the number of files that provided a response to one or more items within a grouping. The purpose of reporting frequency counts is to determine whether SAIR items reflect a degree of construct validity by comparing the findings with convergent and divergent findings in the literature. A discussion of the implications of findings from Part D of SAIR occurs in Chapter Five.

Part Two of Analysis of Data
(Chi Square Contingency Tables)

The Chi Square Distribution Test of Independence

> Chi square is a statistic used to test a null hypothesis, usually based on the comparison of observed and expected frequencies. Observed values of chi square are compared to critical values at a given alpha level (.05 for this study) that presume the null hypothesis is true. (Spence, Cotton, Underwood, & Duncan, 1983).

One of the desirable features of chi square is that it permits hypotheses to be tested about the distribution of individuals among any number of mutually exclusive categories. Chi square probably has its greatest usefulness in testing for significance of differences between groups. Although there may be any number of groups and any number of categories, most often in research there are two groups and two categories of response; the data are expressed in a 2 X 2 table. When chi square is used to test for the significance of a difference between two or more groups, it is said to be a test of *independence*. The concept of independence can be explained using the example of gender categories (male, female) and acknowledgement of substance abuse (yes, no): Are the two ways of classifying observed frequencies independent of each other? If they *are* independent, then frequency for alcohol abuse does *not* depend on gender of victim and may not be considered worthwhile pursuing as a hypothesis as the groups do not differ significantly. On the other hand, if the classifications are *not* independent (i.e., correlated), the data are categorized one way which affects how they are categorized the other way, hence the term contingency tables. This means that the groups differ significantly, the hypothesis of independence is rejected, and we conclude the frequencies in alcohol abuse are probably *not* independent of gender.

In this study, the 452 files were divided into subsamples and the frequency of cases for various items were determined. These files comprise subsamples according to an individual's status in five areas: gender, disability, race, relationship to offender, and generation. Each of the 133 items in Part D of SAIR (Victim Sequelae) were cross-tabulated with the frequency of response in four of the five properties: **gender**, **disability**, **race**, and **relationship of offender and victim**). These same four properties were also cross-tabulated in contingency tables with each of the seven groups of sequelae. This was in an effort to explore hypotheses about the trauma continuum. Categories in **type of historical abuse** were cross-tabulated with categories in **relationship of offender and victim** and **disability** in response to the intergenerational hypothesis.

Limitations to Chi Square Analysis

It is important to note some of the conditions that must be met before data from SAIR may be appropriately analyzed by chi square:

First, chi-square can only be used with frequency (nominal) data that does not allow characteristics to vary in amount (e.g., a yes versus a no response to each item on SAIR). Therefore, all the individuals who check a particular item on SAIR obtain the same score (e.g., a zero or one); there is no variability in response.

Second, the individual observations must be independent of each other. This means an individual's classification according to one property is unrelated to his or her classification according to another property. Each item response in SAIR is considered independent from another. One example from SAIR is **special target groups** (102 with disabilites, 60 Native) and **type of sexual abuse** (four items categorizing degrees of physical intrusiveness). One could argue there is no reason to think that the frequency of response to an item from type of sexual abuse (e.g., very intrusive sexual abuse) is dependent upon or correlated to identity to a special target group.

Third, no theoretical frequency should be smaller than 5. It should be said at the outset that this type of analysis was interpreted with as much precision as possible. That is, data were not reported from any chi square table with more than 20% of its cells having an expected frequency of less than five. Although there is some controversy about "tossing out" this additional data in the statistical literature (base rates controversy), this stringent rule was applied for this analysis in light of the vast amount of bona fide data from the files (i.e., cells with an expected frequency of five or more).

Fourth, there must be some basis for the way the data are categorized. In this study, the items comprising the framework for constructs were conceived and implemented during three phases in the development of SAIR. These included a review of the literature, defining and refining vague and inconsistent constructs in consultation with professionals concerned with CSA, and revisions undertaken during the final phase of coding the data. Reliability was demonstrated by a high degree of agreement among these consultants. The procedures regarding consultation are discussed in Chapter Three.

Fifth, the sum of the expected and the observed frequencies must be the same. Furthermore, both the frequency of occurrence and the frequency of nonoccurrence are used in computing chi square. Chi square analysis takes the sampling distribution of each item and compares this observed distribution of scores to the theoretical or expected frequencies based on the relevant chi square distribution. The expected chi square distribution is contingent upon the degrees of freedom (*df*) . The *df* does not depend on the number of files in the sample, rather it is determined by the number of independent deviations from the observed and expected frequencies. For example, if it were hypothesized there would be no difference in frequency of response to a particular symptom (**alcohol abuse**) for a group of150 individuals of both **gender** (100 females, 50 males), then the response frequency should be proportionately similar. If there were two categories to the item of alcohol abuse (e.g., yes or no) and 70 females and 30 males indicated a positive response to that particular symptom, then 50 individuals (20 males and 30 females) must have responded to the "no" category, and therefore, the deviation is not free to vary.; it must be 50, in order that the expected frequencies sum to the same total as the observed frequencies.

For any table that has at least two rows and two columns, the degrees of freedom is equal to the product of the number of columns minus one and the number of rows minus one: (*df* = number of columns - 1) (number of rows - 1). In this example, there is 1*df* because only one deviation was free to vary in each group and category: (2-1) (2-1), or1*df*.

There is more than one chi-square distribution. Unlike *t* distributions, chi square distributions are not symmetrical, contain no negative scores, and extend theoretically from zero to infinity. Critical values of the two tails differ in value. However, the sampling distribution is similar to the standard normal curve once the *df* exceed 30. In this study frequency distributions vary according to 1, 2, and 3*df*.

A sixth precaution when interpreting findings using chi square concerns the expected number of significant findings when interpreting many tables. For this study, the level of significance (*p*) for the probability of a difference in distribution between groupings was determined to be .05. Therefore, if one were to run 20 chi square tables, one would expect to find a significant result at least once. Considering there are a possible 133 sequelae items in part D of SAIR, one would expect to find significant results approximately 7 (6.7) times due to chance on any run through of the sequelae. Furthermore, the chances of finding significance between distributions among seven groups of sequelae would be rare at this level of significance. Both of these approaches are taken in the analysis of the sequelae (i.e., the seven groupings and 133 individual sequelae are run separately against categories of another variable).

Part two of the statistical analysis uses chi square as an example of how SAIR can be used to generate and explore hypotheses regarding phenomena associated with CSA and target populations.

Data from SAIR can provide target populations either from the primary victims or from selected groups in the genogram (e.g., mothers, stepfathers) or offender population. Two issues are chosen from the literature: the trauma continuum hypothesis and intergenerational hypothesis. Sequelae are cross-tabulated with 10 constructs from SAIR to explore plausible circumstances one might hypothesize are related to subsequent trauma following SA. The intergenerational hypothesis was explored using data from types of abuse in the genogram. These responses are cross-tabulated with (a) categories of relationship of offender and victim, and (b) disabilities.

The purpose of using chi square analysis of the data collected in Phase Two of the construction of SAIR is an attempt to assess a degree of construct validity among the instrument's items. Using target groups within the sample of files to determine differences on a particular item suggests SAIR is a sensitive instrument that is able to distinguish differences among its items. Furthermore, these differences can be related to the literature on CSA to determine whether there is evidence of a preliminary form of convergent or divergent validity among various SAIR items.

Hypotheses Relating to the Trauma Continuum

Events impact on individuals differently because of mediating factors. Browne and Finkelhor (1986) examined factors directly related to the abuse:

> "Several studies indicate that abuse by fathers or stepfathers has a more negative impact than abuse by other perpetrators. Results of some studies also suggest that experiences involving genital contact are more serious, and that the use of force results in more trauma for the victim." (p. 30)

Tsai, Feldman-Summers, and Edgar (1979) found that negative effects of CSA were associated with being older at the time of the last molestation, stronger negative feelings regarding the molestation, and greater frequency and longer duration of molestation. The factors mitigating against negative effects were support from friends and family, and sympathetic sex partners: "Mediating factors may not be variables directly related to the abuse but may include external resources or deficits (e.g., the presence or absence of a social support system, employment) or inner resources or deficits (e.g., intellectual abilities, physical health, inherited strengths and vulnerabilities)" (Asher, 1988).

There is increasing support in the literature for the hypothesis that the degree of post traumatic stress syndrome (PTSD) following CSA may be significantly related to factors such as the relationship of the offender and the victim, whether the abuse was a single incident or of a repeated nature, the degree of intrusiveness of the SA, whether or not there was concurrent physical, emotional and/or neglectful abuse, and the duration of the abuse.

For this study, the number of selected sequelae provide an indication of the degree of trauma experienced by the victim. Therefore, it could be argued that the five individuals from the sample of files who appeared to have no sequelae, are the most likely to be be suffering from the least trauma, if any at all. On the other hand, it could be argued that their trauma is so extensive that it has been "repressed" or buried in the subconscious and has yet to "rear its ugly head" during a new stage or particular experience in the victim's life. Each individual sequelae (*n* =133) and seven group sequelae were cross-tabulated with 10 SAIR constructs: **(1)** relationship of offender and victim (part 1), **(2)** number of offenders, **(3)** number of incidents, **(4)** relationship of offender and victim (part 2), **(5)** degree of intrusiveness, **(6)** concurrent abuse, **(7)** disability (all 102 individuals with disabilities), **(8)** disability (51 in the special program), **(9)** race, and **(10)** gender.

Tables of Significant Findings From Chi Square Analysis

The results shown in the tables 42 through 55 reflect the frequency of positive responses in each category followed by the percentage of that response in parenthesis. The first comparison of distributions is shown in Table 42. The sample size was 440 (intra

197, extra 194, both 49). Although some of the files were able to provide information about the number of offenders, they did not contain information about the relationship of the offender and the victim. In this sample of files, 249 offenders out of the possible 689 were not able to be identified as to their relationship to the victim. Therefore, as in the frequency tables in part one of this chapter, data should be interpreted with caution as actual percentages are based on 440 known relationships or 63.9 percent of the recorded offenders in the file sample.

All tables in this section of the results (chi square analysis) show the frequency of contingent response from the chi square tables. Each frequency count is followed in parenthesis by a percentage representing the proportion of the category which contributed the most to the significant distribution differences in the observed and expected frequencies and, therefore, suggests that two categories in sequelae and group may be related.

Table 42

Classification of Relationship X Sequelae Group

Sequelae Group	Intra (n=197)	Extra (n=194)	Both (n=49)	p value
Sexuality	115 (58.4)	111 (57.2)	38 (77.6)	$p < .03$
Medical or Somatic Complaints	59 (29.9)	48 (24.7)	23 (46.9)	$p < .01$

* Actual percentages based on 440 (63.9%) recorded cases.

Of the seven sequelae groupings, Table 42 shows that there was a significant difference in distribution with two sequelae groups (sexuality and medical or somatic complaints) among the three categories of classification for relationship: **intra** (intrafamilial), **extra** (extrafamilial), and **both** (i.e., victim has had at least one offender in each of intrafamilial and extrafamilial categories). Proportions for each distribution indicate that the difference comes from the category of **both**. In this study, those who have been victimized by someone within and outside the family appear to develop various problems with their sexual development and/or their bodily functioning. Table 43 provides a specific look at individual sequelae items for these three relationship groups.

Table 43

Classification of Relationship X Individual Sequelae

Individual Sequelae Item	Intra (n=197)	Extra (n=194)	Both (n=49)	p value
School/Work/Social Activities				
Extremely demanding or withdrawn at routine activities	16 (8.1)	17 (8.8)	13 (25.5)	$p< .0005$
Extremely demanding	6 (3)	7 (3.6)	8 (16.3)	$p< .0003$
Unwillingness to undress for gym	9 (4.6)	4 (2.1)	5 (10.2)	$p< .03$
Personal Relationships				
Is easily led or influenced/tries hard to please others	26 (13.2)	40 (20.6)	20 (40.8)	$p< .001$
Role refersal/enmeshment with parent	29 (14.7	19 (9.8)	17 (34.7)	$p< .001$
Repeats pattern of engaging in abusive relationships	15 (7.6)	14 (7.2)	16 (32.7)	$p< .001$
Sexuality				
Has difficulty distinguishing between affection and sexual encounters	44 (22.3)	28 (14.4)	16 (32.7)	$p< .01$
Uses sexuality for approval seeking from adults or children	22 (11.2)	20 (10.3)	15 (30.6)	$p< .001$
Approaches strangers inappropriately/poor sense of personal safety	45 (22.8)	30 (15.5)	22 (44.9)	$p< .001$
Bedtime				
Has nightmares or recurring dreams on a regular basis	66 (33.5)	76 (39.2)	49 (55.1)	$p< .02$
Hygiene				
Exhibits excessive modesty surrounding bath/bedroom functions	8 (4.1)	4 (2.1)	5 (10.2)	$p< .03$
Becomes agitated during bath/bedroom routines	4 (2)	13 (6.7)	4 (8.2)	$p< .05$
Medical and/or Somatic Complaints				
Regular headaches	12 (6.1)	10 (5.2)	9 (18.4)	$p< .004$
Regular stomach aches	17 (8.6)	16 (8.2)	11 (22.4)	$p< .01$
Pregnancy inappropriate for age or partner	6 (3)	4 (2.1)	5 (10.2)	$p< .02$
Appeas accident or illness prone	14 (7.1)	10 (5.2)	8 (16.3)	$p< .03$

Table 43 cont'd

Classification of Relationship X Individual Sequelae

Individual Sequelae Item	Intra (*n*=197)	Extra (*n*=194)	Both (*n*=49)	*p* value
Emotional/Behavioral Lability				
Shows a sudden behavior change	49 (24.9	64 (33)	22 (44.9)	$p<.02$
Appears depressed, threatens or attempts suicide	80 (40.6	60 (30.9	29 (59.2)	$p<.001$
Appears depressed on a regular basis	65 (33)	53 (27.3	23 (46.9)	$p<.03$
Attempts suicide or has in past	22 (11.2)	6 (3.1)	8 (16.3)	$p<.001$
Fears/Anxieties/Phobias				
Has memories or fears of choking, suffocating, stuttering	6 (.03)	3 (.02)	4 (.08)	$p<.05$
Expresses fear about losing control & becoming abusive to self/others	15 (7.6)	10 (5.2)	8 (16.3)	$p<.03$
Eating Disorders and Substance Abuse				
Shows increase in appetite (Overeating, weight gain)	10 (5.1)	6 (3.1)	7 (14.3)	$p<.01$
Abuse of alcohol and/or drugs	14 (7.1)	12 (6.2)	8 (16.3)	$p<.05$
Poor Self Esteem				
Is overly passive and unassertive	29 (14.7)	17 (8.8)	14 (28.6)	$p<.001$
Expresses an inordinate amount of guilt/shame/discontent with body	100 (50.8)	100 (51.5)	34 (69.4)	$p<.05$
Assumes victim role	22 (11.2)	25 (12.9)	14 (28.6)	$p<.006$
Dissociative Episodes				
Tendency to withdraw into fantasy	13 (6.6)	15 (7.7)	11 (22.4)	$p<.002$
Inability to focus/sustain attention	41 (20.8)	24 (12.4)	19 (38.8)	$p<.001$
Intense ego states	18 (9.10	11 (5.7)	11 (22.4)	$p<.001$
Repressed childhood memories	33 (16.8)	17 (8.8)	8 (16.3)	$p<.05$
Experiences dissociative episodes	68 (34.5)	45 (23.2)	30 (61.2)	$p<.001$
Unwilling/unable talk feelings	76 (38.6)	51 (26.3)	9 (18.4)	$p<.004$
Engages in self abuse	27 (13.7)	13 (6.7)	12 (24.5)	$p<.001$
Other Developmental Problems				
Regressive behavior (baby talk)	6 (3)	3 (1.5)	4 (8.2)	$p<.05$
Displays attention seeking/needy behavior	36 (18.3)	44 (22.7)	18 (36.7)	$p<.02$

Table 42 shows a remarkable consistency in significant differences between relationship groups. All but one of the 36 significant difference items were in the direction of the **both category**. The one significant item in the direction of intrafamilial relationships is an **inability or unwillingness to discuss personal feelings**.

Sequelae outcomes were also analyzed by **number of offenders**. As in the case with relationship, this was done by both the seven major groups and by the 133 individual sequelae items. Surprisingly, not a single significant difference was found in any of the distributions.

The next step was to determine if there would be significant differences in the distributions if the **number of incidents** was considered. In order to obtain as much data as possible, files were coded as **once, two to 10X**, and **more than 10X**. Some refinement was completed on the coding of this data in the following manner. Those files that had more than one offender and one incident for each offender represented victims who had actually been SA abused more than one time. Therefore, each victim was recoded. For example, if a victim had three offenders and all were one time incidents, the number of incidents was coded in the category named 2 to 10X. Likewise, if a victim had indicated the abuse happen 2 to 10X with five separate offenders, then the number of incidents was recoded as happening more than 10X. This allowed for the minimal amount of possible incidents to be used in the chi square calculations from 420 victims. Sample size is shown in Table 43.

Results for the groups revealed a significant difference for group sequelae in **personal relationships** (p<.001), **sexuality** (p<.001) and **medical/somatic complaints**, (p<.009), all of which were in the direction of **more than 10X**. Furthermore, the next highest percentage consistently came from the 2 to10X category, followed by the lowest percentages in the **once** category. Results for individual sequelae are shown below.

Table 44

Number of Incidents X Individual Sequelae Items

Individual Sequelae Item	Once (*n*=83)	2-10X (*n*=169)	more 10X (*n*=168)	*p* value
School/Work/Social Activities				
Refuses to participate in daily activities	5 (6)	33 (19.5)	36 (21.4)	$p < .007$
Unwillingness to undress for gym	2 (2.4)	2 (.01)	13 (7.7)	$p < .007$
Personal Relationships				
Role refersal/enmeshment with parent	6 (7.2)	14 (8.3)	42 (25)	$p < .001$
Repeats pattern of engaging in abusive relationships	3 (3.6)	15 (8.9)	27 (16.1)	$p < .007$
Inability to establish trusting relationships	19 (22.9)	38 (22.5)	70 (41.7)	$p < .001$
Displays aggressive or dominant behavior	22 (26.5)	77 (45.6)	80 (47.6)	$p < .004$
Shows inappropriate anger	15 (18.1)	62 (36.7)	63 (37.5)	$p < .004$
Sexuality				
Has difficulty distinguishing between affection and sex	2 (2.4)	37 (21.9)	45 (26.8)	$p < .001$
Sexual promiscuity/knowledge	2 (2.4)	22 (13)	39 (23.2)	$p < .001$
Inappropriate touching	11 (13.3)	44 (26)	28 (16.7)	$p < .02$
Confused about sexual orientation	0 (0)	3 (1.8)	11 (6.5)	$p < .01$
Sexual dysfunction	4 (4.8)	17 (10.1)	30 (17.9)	$p < .01$
Poor sense of personal safety	9 (10.8)	47 (27.8)	37 (22)	$p < .01$
Dresses seductively	0 (0)	4 (2.4)	10 (6)	$p < .03$
Preoccupied with sexual thoughts	1 (1.2)	18 (10.7)	15 (8.9)	$p < .03$
Hygiene				
Exhibits excessive modesty during bath/bedroom functions	3 (3.6)	2 (1.2)	12 (7.1)	$p < .02$
Medical and/or Somatic Complaints				
Regular headaches	3 (3.6)	9 (5.3)	19 (11.3)	$p < .04$
Pregnancy inappropriate for age or partner	0 (0)	4 (2.4)	10 (6)	$p < .03$

Table 44 cont'd

Number of Incidents X Individual Sequelae

Individual Sequelae Item	Once (*n*=83)	2-10X (*n*=169)	more 10X (*n*=168)	*p* value
Emotional/Behavioral Lability				
Appears depressed, threatens or attempts suicide	17 (20.5)	54 (32)	91 (54.2)	$p < .001$
Appears depressed on a regular basis	15 (18.1)	47 (27.8)	71 (42.3)	$p < .001$
Attempts suicide or has in past	1 (1.2)	10 (5.9)	26 (15.5)	$p < .001$
Runs away/threatens to run away	2 (2.4)	16 (9.5)	26 (15.5)	$p < .005$
Intense anger towards (person)	12 (14.5)	43 (25.4)	48 (28.4)	$p < .05$
Homicidal ideation	14 (16.9)	44 (26)	56 (33.3)	$p < .02$
Threatens to hurt self/suicide	1 (1.2)	6 (3.6)	13 (7.7)	$p < .05$
Fears/Anxieties/Phobias				
Expresses fear about losing control & becoming abusive to self/others	2 (2.4)	9 (5.3)	20 (11.9)	$p < .01$
Flashbacks of abuse	5 (6)	11 (6.5)	26 (15.5)	$p < .009$
Has memories/fears of choking, suffocating	2 (2.4)	1 (.6)	10 (6)	$p < .02$
Experiences panic attacks	2 (2.4)	6 (3.6)	15 (8.9)	$p < .04$
Shows phobic avoidance behavior	8 (9.6)	22 (13)	41 (24.4)	$p < .003$
Eating Disorders and Substance Abuse				
Change in appetite/eating habits	8 (9.6)	23 (13.6)	46 (27.4)	$p < .001$
Decrease/anorexia/bulemia	3 (3.6)	11 (6.5)	26 (15.5)	$p < .002$
Increase/overeating/weight gain	4 (4.8)	4 (2.4)	14 (8.3)	$p < .05$
Substance abuse	4 (4.8)	25 (14.8)	33 (19.6)	$p < .008$
Abuse of alcohol	4 (4.8)	14 (8.3)	26 (15.5)	$p < .02$
Abuse of drugs	2 (2.4)	12 (7.1)	22 (13.1)	$p < .01$
Poor Self Esteem				
Discontent with body image	4 (4.8)	18 (10.7)	28 (16.7)	p< .02
Expresses an inordinate amount of guilt/shame	12 (14.5)	27 (16)	47 (28)	p< .05
Assumes victim role	6 (7.2)	22 (13)	33 (19.6)	p< .02

Table 44 cont'd

Number of Incidents X Individual Sequelae

Individual Sequelae Item	Once (n=83)	2-10X (n=169)	more 10X (n=168)	p value
Dissociative Episodes				
Experiences dissociative episodes	12 (14.5)	40 (23.7)	83 (49.4)	$p< .001$
Intense ego states	2 (2.4)	9 (5.3)	30 (17.9)	$p< .001$
Inability to focus/sustain attention	6 (7.2)	24 (14.2)	49 (29.2)	$p< .001$
Repressed childhood memories	4 (4.8)	12 (7.1)	37 (22)	$p< .001$
Engages in self abuse	1 (1.2)	19 (11.2)	33 (19.6)	$p< .001$
Cognition detached from emotion	27 (32.5)	61 (36.1)	81 (48.2)	$p< .02$
Withdraws into fantasy regularly	3 (3.6)	12 (7.1)	23 (13.7)	$p< .02$
Other Developmental Problems				
Regressive behavior (baby talk)	1(1.2)	3 (1.8)	10 (6)	$p< .05$

Table 44 shows an extensive number of significant differences in the distributions among categories of number of incidents. All but two of the 44 differences were in the direction of **more than 10X**. These were **inappropriate touching of self or others** and **poor sense of personal safety**. These two items were in the direction of 2 **to10X**.

The last step in the chi square analysis regarding possible differences in trauma outcome and the relationship between the offender and the victim follows. This time, those files that recorded victims experiencing either intrafamilial or extrafamial abuse were compared, regardless of number of offenders, and also excluding the 49 files from the "both" category. The sample size was 391. Crosstabs were calculated for both the sequelae groupings and all individual sequelae items.

Table 45

Classification of Relationship X Individual Sequelae (Intrafamilial vs Extrafamilial)

Individual Sequelae Item	Intra (n=197)	Extra (n=194)	p value
School/Work/Social Activities			
Avoids school, work, social responsibilities	32 (16.2)	48 (24.7)	$p<.04$
Personal Relationships			
Is easily led or influenced/tries hard to please others	26 (13.2)	40 (20.6)	$p<.05$
Sexuality			
Has difficulty distinguishing between affection and sexual encounters	44 (22.3)	28 (14.4)	$p<.04$
Hygiene			
Becomes agitated during bath/bedroom routines	4 (2)	13 (6.7)	$p<.05$
Emotional/Behavioral Lability			
Attempts suicide or has in past	22 (11.2)	6 (3.1)	$p<.002$
Appears depressed, threatens or attempts suicide	80 (40.6)	60 (30.9)	$p<.05$
Detachment of cogntion and emotion	93 (47.2)	64 (33)	$p<.004$
Dissociative episodes/identity disorder	68 (34.5)	45 (23.2)	$p<.01$
Unwilling/unable to talk feelings	76 (38.6	51 (26.3	$p<.009$
Inability to sustain attention	41 (20.8)	24 (12.4)	$p<.02$
Repressed childhood memories	33 (16.8	17 (8.8)	$p<.02$
Engages in self abuse	27 (13.7)	13 (6.)	$p<.02$
Displays intense fear of person	41 (20.8)	26 (13.4)	$p<.05$
Medical and/or Somatic Complaints			
Has pain in anal, genital, gastrointestinal, or urinary area	13 (6.6)	4 (2.1)	$p<.03$

No differences between the distributions were shown for any of the groupings of sequelae except for items related to **school, work, or social activities** ($p<.03$). Calculated percentages reveal the direction to be **extrafamial.** Frequency distributions for the intrafamilial classification were 49.7% (98 out of 197) whereas, they were 60.8% for extrafamilial category (118 out of 194).

The results for the cross-tabulations of these groups with individual sequelae are shown in Table 45. There were 14 significant differences in the distributions, all but three in the direction of **intrafamilial** abuse. A closer inspection of these results shows that the vast number of individual items come from the behavioral/emotional grouping of symptoms. (i.e., nine of the 14 significant items).

The fifth analysis relating to issues regarding trauma and its after effects is that of whether the degree of intrusiveness **(type of SA)** may possibly be related to any groups or items of sequelae. A chi-square table was run for each of these frequency distributions. Sequelae group results indicate there were two significant differences in the distributions of sequelae: **school, work, social activities** ($p<.02$) and **sexuality** ($p<.001$). These groupings were in the direction of the **very intrusive** category.

Table 46

Type of Sexual Abuse X Sequelae Items
(Degree of Intrusiveness)

Individual Sequelae Item	1 Least $n=223$	2 Less $n=174$	3 Intr $n=16$	4 Very $n=15$	p value
Behavioral/Emotional Lability					
Experiences dissociative episodes	1 (6.7)	5 (31.3)	44 (25.3)	89 (39.9)	$p<.003$
Cognition detached from emotion	2 (13.3)	3 (18.8)	65 (37.4)	102 (45.7)	$p<.01$
Depressed on a regular basis	1 (6.7)	1 (6.3)	54 (31)	79 (35.4)	$p<.01$
Depressed, threatens or attempts suicide	1 (6.7)	2 (12.5)	61 (35.1)	99 (44.4)	$p<.002$

Results from individual sequelae are shown in Table 46. Degree of intrusiveness is shown from the least intrusive category (1) to the most intrusive (4). Results show few differences in distributions, except with four sequelae items: two relating to dissociation and two dealing with depression. All significant results are in the direction of the most intrusive type of SA.

Table 47

Concurrent Abuse X Sequelae Item

Individual Sequelae Item	Additional Abuse (n=120)	No Other Abuse (n=332)	p value
School/Work/Social Activities			
Extremely demanding	11(9.2)	11 (3.3)	$p< .01$
Personal Relationships			
Shows inappropriate anger	54 (45)	96 (28.9)	$p< .001$
Has few friends	37 (30.8)	72 (21.7)	$p< .04$
Repeats pattern of engaging in abusive relationships	21 (17.5)	24 (7.2)	$p< .001$
Sexuality			
Preoccupied with sexual thoughts	4 (3.3)	33 (9.9)	$p< .02$
Bedtime			
Has nightmares or recurring dreams on a regular basis	58 (48.3)	114 (34.3)	$p< .007$
Medical and/or Somatic Complaints			
Nervous disorders	29 (24.2)	44 (13.3)	$p< .005$
Regular headaches	15 (12.5)	16 (4.8)	$p< .004$
Has bruises, scratches, bites, etc.	8 (6.7)	7 (2.1)	$p< .001$
Pregnancy inappropriate for age or partner	8 (6.7)	4 (1.2)	$p< .02$
Sexually transmitted diseases	10 (8.3)	11 (8.3)	$p< .03$

Table 47 cont'd

Concurrent Abuse X Sequelae Item

Individual Sequelae Item	Additional Abuse (*n*=120)	No Other Abuse (*n*=332)	*p* value
Emotional/Behavioral Lability			
Change in eating behaviors	29 (24.2)	51 (15.4)	$p<.03$
Decrease in appetite/weight loss	19 (15.8)	23 (6.9)	$p<.004$
Attempted suicide following abuse	18 (15)	19 (5.7)	$p<.001$
Memories or fears of choking or suffocating	9 (7.5)	4 (1.2)	$p<.001$
Fear of a specific person, place. or situation	43 (35.8)	88 (26.5)	$p<.05$
Phobic behaviors	27 (22.5)	52 (15.7)	$p<.04$
Inability to sustain attention	33 (27.5)	48 (14.5)	$p<.004$
Multiple personality disorder	6 (5)	1 (.3)	$p<.001$
Self abuse	20 (16.7)	33 (9.9)	$p<.05$
Needy/attention-seeking behavior	39 (32.5)	61 (18.4)	$p<.001$
Assumes victim role	25 (20.8)	37 (11.1)	$p<.008$

A sixth analysis of the sequelae was compared to whether there was concurrent abuse from the offender. Three types of additional abuse were possible (PA, neglect, and EA). Again, a comparison with both sequelae groups and individual items was completed. The results from the groups of sequelae showed significant differences in distributions in **personal relationships** ($p<.05$) and in **medical or somatic complaints** ($p<.001$). Both differences are in the direction of the **concurrent abuse (additional abuse) category**.

Results for individual sequelae items (Table 47) indicate there were 23 significant differences in the item distributions, all but one in the direction of the **concurrent abuse victims**. The only item directed toward the non-concurrent abuse category of victims was **preoccupied with sexual thoughts**.

Table 48

Duration of Abuse in Quartiles X Sequelae Items

Individual Sequelae Item	1st quart n=222	2nd quart n=70	3rd quart n=68	4th quart n=92	p value
School/Work/Social Activities					
Refuses to participate in regular routines	25 (11.3)	16 (22.9)	15 (22)	23 (25)	$p < .008$
Personal Relationships					
Shows inappropriate anger	61 (27.5)	27 (38.6)	19 (27.9)	43 (46.7)	$p < .05$
Has few friends	46 (20.7)	15 (21.4)	15 (22.1)	33 (35.9)	$p < .03$
Inability to establish trusting relationships	56 (25.2)	16 (22.9)	19 (27.9)	42 (45.7)	$p < .002$
Role refersal/enmeshment with parent	20 (9)	12 (17.1)	9 (13.2)	25 (27.2)	$p < .001$
Repeats pattern of engaging in abusive relationships	14 (6.3)	6 (8.6)	7 (10.3)	18 (19.6)	$p < .005$
Sexuality					
Has difficulty distinguishing between affection and sexual encounters	33 (14.9)	10 (14.3)	14 (20.6)	32 (34.8)	$p < .001$
Sexual dysfunction	17 (7.7)	6 (8.6)	10 (14.7)	18 (19.6)	$p < .01$
Bedtime					
Has nightmares or recurring dreams on a regular basis	82 (36.9)	22 (31.4)	22 (32.4)	46 (50)	$p < .05$
Medical and/or Somatic Complaints					
Nervous disorders	30 (13.5)	8 (11.4)	9 (13.2)	26 (28.3)	$p < .005$

Table 48 cont'd

Duration of Abuse in Quartiles X Sequelae Items

Individual Sequelae Item	1st quart *n*=222	2nd quart *n*=70	3rd quart *n*=68	4th quart *n*=92	*p* value
Emotional/Behavioral Lability					
Attempted suicide following SA	10 (4.5)	2 (2.9)	7 (10.3)	18 (19.6)	$p < .001$
Depressed, threatens or attempts suicide	63 (28.4)	24 (34.3)	35 (51.5)	51 (55.4)	$p < .001$
Depressed on a regular basis	53 (23.9)	21 (30)	30 (44.1)	39 (42.4)	$p < .001$
Fears and Phobias					
Displays phobic behavior	32 (14.4)	2 (2.9)	12 (17.6)	29 (31.5)	$p < .001$
Fear of losing control and hurting self or others	12 (5.4)	3 (4.3)	3 (4.4)	16 (17.4)	$p < .001$
Has flashbacks of abuse	20(9)	0 (0)	5 (7.4)	19 (20.7)	$p < .001$
Poor Self-Esteem					
Assumes victim role	22 (9.9)	9 (12.9)	11 (16.2)	20 (21.7)	$p < .04$
Discontent with body image	21 (9.5)	4 (5.7)	8 (11.8)	19 (20.7)	$p < .01$
Eating Disorders and Substance Abuse					
Substance abuse	27 (12.2)	6 (8.6)	9 (13.2)	23 (25)	$p < .01$
Alcohol abuse	19 (8.6)	4 (5.7)	5 (7.4)	18 (19.6)	$p < .009$
Drug abuse	12 (5.4)	3 (4.3)	6 (8.8)	15 (16.3)	$p < .007$
Change in eating behavior	29 (13.1)	9 (12.9)	15 (22.1)	27 (29.3)	$p < .003$
Dissociative Experiences					
Experiences dissociative episodes	57 (25.7)	15 (21.)	21 (30.9)	55 (59.8)	$p < .001$
Intense ego state changes	7 (3.2)	6 (8.6)	7 (10.3)	21 (22.8)	$p < .001$
Cognition detached from emotion	75 (33.8)	26 (37.1)	30 (44.1)	52 (56.5)	$p < .002$
Self abuse	16 (7.2)	6(8.6)	12 (17.6)	19 (20.7)	$p < .002$
Repressed memories from childhood	19 (8.6)	6 (8.6)	7 (10.3)	27 (29.3)	$p < .001$
Flat/inappropriate affect	26 (11.7)	10 (14.3)	6 (8.8)	27 (29.3)	$p < .001$
Inability to keep attention	30 (13.5)	8 (11.4)	12 (17.6)	35 (38)	$p < .001$
Other Developmental Problems					
Regressive behavior	46 (20.7)	26 (37.1)	18 (26.5)	12 (13)	$p < .003$
Enuresis following abuse	19 (8.6)	16 (22.9)	8 (11.8)	2 (2.2)	$p < .001$

A seventh and last hypothesis related to the issue of the continuum of trauma investigates the possibility of **duration of abuse** as having some relationship to the effects of SA. The coding procedure for this variable was to divide the range of number of months into four quartiles for the purposes of determining number of **offender months**. The split between the first and second quartiles was at the 25th percentile, which meant all those incidents reporting a duration of less than 12 months fell into this quartile, including one time incidents. The next split was at the 50th percentile (under 24 months duration), and the last split was at the 75th percentile (under 48 months duration). Frequencies for each category can be seen in Table 48.

Approximately half of the victims (49.1%) fell into the least amount of abuse time, with the remaining half in the upper three quartiles of duration of abuse. Results of these levels with the sequelae groups found four significant differences in the sequelae groups in the direction of the fourth quartile (i.e., those whose SA went on for the longest duration of time). The significance for each groups is as follows: **school, work, or social activities** ($p<.25$), **personal relationships** ($p<.007$), **sexuality** ($p<.006$), and **medical or somatic complaints** ($p<.004$).

Results from the individual items show 31 significant differences, all but two in the direction of the longest duration. The two items that were significant for the direction of the second quartile both concern regressive behaviors following the SA.

Using quartiles to divide the number of months the abuse continued (a one time incident was also recorded as one month) allows for the possibility of cross-tabulating a particular quartile with another construct such as classification of SA (intrafamilial or extrafamilial or both) and then determining if there are differences in outcomes of sequelae. Such research using SAIR is welcomed.

Target Populations

Tables 49 through 52 reveal significant chi square results using sequelae items and groups with five target populations: (1) 350 individuals with **no disabilitiy (ND)**, (2) the **total** 102 individuals with any type of disability **(TD)**, (3) 51 disabled who were in the new **program (PD)**, (4) 60 **Native** people, and (5) 392 **non-Native** people. Table 49 shows the results from two chi square tests: (1) sequelae groups crossed with ND and TD groups and (2) sequelae groups crossed with ND and PD groups. It is assumed that those in the program generally tend to have more severe handicaps than those not in the program. (Table 2 revealed 32 of the 41 (78%) developmentally delayed clients were clients in the special program. In contrast the same proportion (78%) of the clients classified as borderline and low average are not in the program. These same groups classified according to disability were crossed again with each of the 133 sequelae items. Results from individual sequelae items are shown for the ND and TD groups in Table 50. Table 51 reveals significant results from individual sequelae items and ND and PD. The last of the target populations within the sample focused on Native clients compared to non-Natives.

There were two major areas in which the TD population had a significant difference in distribution than the nondisabled. These were in **sexuality** and **hygiene**. This was also the case when comparing the distributions of the PD, except that this last group had an additional significant group difference in **bedtime** routines. A summation of these two chi square analysis can be seen in Table 49.

Table 49

Disability Group X Sequelae Groups

Sequelae Group	No Disability (n=350)	All with Disability (n=102)	p value	No Disability (n=350)	Disabled Program (n=51)	p value
sexuality	200 (57.1)	71 (69.6)	$p<.02$	200 (57.1)	43 (84.3)	$p<.001$
hygiene	42 (12)	33 (32.3)	$p<.001$	42 (12%)	21 (41%) (1	$p<.001$
bedtime				169 (48.3)	32 (62.7)	$p<.05$

Table 50

Disability X Sequelae Items
(All Disabilities or No Disability)

Individual Sequelae Item	Total (n=102)	Non (n=350)	p value
School/Work/Social Activities			
Extremely demanding/withdrawn	19 (18.6)	28 (8)	$p< .002$
Extremely demanding	9 (8.8)	13 (3.7)	$p< .03$
Extremely withdrawn	10 (9.8)	13 (3.7)	$p< .01$
Sexualized/bizarre artwork	12 (11.8)	15 (4.3)	$p< .005$
Personal Relationships			
Displays dominant/aggressive behavior towards others	53 (52)	143 (40.9)	$p< .05$
Shows inappropriate emotional response	44 (43.1)	106 (30.3)	$p< .02$
Sexuality			
Has difficulty distinguishing between affection and sexual encounters	30 (29.4)	59 (16.9)	$p< .005$
Presents as a little adult	4 (3.9)	45 (12.9)	$p< .01$
Little or no age appropriate sexual knowledge	22 (21.6)	2 (.6)	$p< .001$
Verbalizes inappropriate sexual remarks	23 (22.5)	31 (8.9)	$p< .001$
Approaches strangers inappropriately	36 (35.3)	61 (17.4)	$p< .001$
Hygiene			
Appears unkempt/dirty or is overly concerned with cleanliness	13 (12.7)	20 (5.7)	$p< .02$
Behavioral/Emotional Lability			
Tendency to withdraw into fantasy	18 (17.6)	22 (6.3)	$p< .02$
Makes unusual comments about home/family life	16 (15.7)	18 (5.1)	$p< .04$

All except one of the 15 significant distributions was in the direction of the TD group. Only **presents as a little adult** suggests a relation to the nondisabled. Table 51 compares the individual sequelae with the PD and ND groups. Again, all differences but one are in the direction of the PD group: **an inability or unwillingness to discuss personal feelings about the SA** suggests a relationship with those without disabilities.

Table 51

Disability Group X Sequelae Items
(Program Disabled or No Disability)

Individual Sequelae Item	Program (n=51)	No Disability (n=350)	p value
School/Work/Social Activities			
Extremely demanding/withdrawn	16(31.4)	28 (8)	$p < .001$
Personal Relationships			
Is easily led or influenced/tries hard to please others	17 (33.3)	60 (17.1)	$p < .006$
Regularly shows inappropriate emotional response	24 (47.1)	106 (30.3)	$p < .02$
Sexuality			
Has difficulty distinguishing between affection and sexual encounters	18 (35.3)	59 (16.9)	$p < .002$
Verbalizes inappropriate sexual remarks	14 (27.5)	31 (8.9)	$p < .001$
Approaches strangers inappropriately/poor sense of personal safety	16 (31.4)	61 (17.4)	$p < .001$
Bedtime			
Has nightmares or recurring dreams on a regular basis	27 (52.9)	131 (37.4)	$p < .03$
Behavioral/Emotional Lability			
Phobias/intense fear of specific person, place, or situation	14 (27.5)	56 (16)	$p < .04$
Inordinate amount of guilt	16 (31.4)	61 (17.4)	$p < .02$
Discontent with body image	13 (25.5)	35 (10)	$p < .001$
Assumes victim role	13 (25.5)	47 (13.4)	$p < .02$
Unwilling/unable to discuss feelings	7 (13.7)	113 (32.3)	$p < .001$
Engages in self abuse	15 (29.4)	36 (10.3)	$p < .001$
Medical and/or Somatic Complaints			
Complains of stomach aches	11 (21.6)	31 (8.9)	$p < .004$

A comparison of seven groups of sequelae and Native and non-Native clients revealed there were no significant differences in frequency distributions. Of all the 133 individual sequelae, there were only two differences found in distributions. However, these two significant differences were split in their direction. Chi square shows there may be a relationship between Native clients and **some type of sleep disorder** ($p<.007$). Non-Natives tend to have **repressed memories from childhood** ($p<.05$) more than Native clients.

Table 52

Gender X Sequelae Item

Individual Sequelae Item	Male (n=115)	Female (n=336)	p value
School/Work/Social Activities			
Sexualized, bizarre art or stories	13 (11.3)	14 (41.7)	$p< .005$
Avoids daily school or work routines	15 (13)	80 (23.8)	$p< .01$
Insists on attending activities	1 (.9)	17 (5)	$p< .05$
Personal Relationships			
Is easily led or influenced/tries hard to please others	13 (11.3)	73 (21.7)	$p< .01$
Pattern of engaging in abusive relationships	3 (2.6)	41 (12.2)	$p< .003$
Role reversal/enmeshment with parent	6 (5.2)	59 (17.6)	$p< .001$
Inability to establish trusting relationships	25 (21.7)	107 (31.8)	$p< .04$
Displays aggressive behavior	65 (56.5)	131 (39)	$p< .001$
Shows inappropriate anger	50 (43.5)	100 (29.8)	$p< .007$

Table 52 cont'd

Gender X Sequelae Item

Individual Sequelae Item	Male (*n*=115)	Female (*n*=336)	*p* value
Sexuality			
Has difficulty distinguishing between affection and sex	14 (12.2)	75 (22.3)	*p*< .02
Inappropriate touching self/others	45 (39.1)	50 (14.9)	*p*< .001
Touches children inappropriately	36 (31.3)	31 (9.2)	*p*< .001
Initiates sexual games with children	25 (21.7)	20 (6)	*p*< .001
Dresses inappropriately (seductively or layering)	2 (1.7)	26 (7.7)	*p*< .02
Experiences sexual dysfunction	1 (.9)	49 (14.6)	*p*< .001
Initiates sexual games with adults	32 (27.8)	33 (9.8)	*p*< .001
Presents as a little adult	4 (3.5)	45 (13.4)	*p*< .003
Masturbates excessively for age	15 (13)	15 (4.5)	*p*< .001
Inappropriate sexual remarks	22 (19.1)	32 (9.5)	*p*< .006
Approaches strangers inappropriately/poor sense of personal safety	16 (13.9)	81 (24.1)	*p*< .02
Bedtime			
Regularly has nightmares or recurring dreams	33 (28.7)	139 (41.4)	*p*< .02
Medical and/or Somatic Complaints			
Sexually transmitted disease	1 (.9)	20 (6)	*p*< .03
Has regular stomach aches	5 (4.3)	39 (11.6)	*p*< .02

Table 52 cont'd

Gender X Sequelae Item

Individual Sequelae Item	Male (n=115)	Female (n=336)	p value
Emotional/Behavioral Lability			
Depressed, threatens or attempts suicide	29 (25.2)	144 (42.9)	$p < .001$
Depressed on a regular basis	27 (23.5)	116 (34.5)	$p < .03$
Attempted suicide following abuse	3 (2.6)	34 (10.1)	$p < .01$
Fears, Anxieties, Phobias			
Has flashbacks of abuse	2 (1.7)	42 (12.5)	$p < .001$
Fear of losing control and hurting self or others	3 (2.6)	31 (9.2)	$p < .02$
Phobic behaviors	8 (7)	67 (19.9)	$p < .001$
Eating Disorders and Substance Abuse			
Substance abuse (any type)	6 (5.2)	59 (17.6)	$p < .001$
Alcohol abuse	3 (2.6)	43 (12.8)	$p < .002$
Drug abuse	1 (.9)	35 (10.4)	$p < .001$
Change in eating behavior	11 (9.6)	69 (20.5)	$p < .008$
Overeating, weight gain since sexual abuse	1 (.9)	22 (6.5)	$p < .02$
Poor Self Esteem			
Unassertive, overly passive	6 (5.2)	54 (16.1)	$p < .003$
Assumes "victim" role	8 (7)	54 (16.1)	$p < .01$
Discontent with body image	7 (6.1)	45 (13.4)	$p < .03$
Dissociative Experiences			
Experiences dissociative episodes	23 (20)	124 (36.9)	$p < .001$
Repressed memories from childhood	5 (4.3)	54 (16.1)	$p < .001$
Other Developmental Problems			
Regressive behavior	36 (31.3)	66 (19.6)	$p < .01$

Gender

A third theme which runs through the current literature has to do with possible differences in the way males and females react to the trauma of CSA. To test the possibility of this hypothesis, the sequelae groups and individual items were crossed with gender. The results from the sequelae groups showed no significant differences in any of the distributions. Table 52 displays the significant differences for the individual items and gender categories.

Of the 40 significant differences in distributions, 31 were in the direction of females, and nine were in the direction of males. Females tended to respond with eating disorders and substance abuse, fears, anxieties, and dissociative episodes. Males tended to respond with aggression and anger, especially related to acting out sexually.

The Intergenerational Hypothesis

The second hypothesis explored for chi square analysis using SAIR data has nothing to do with resulting sequelae, but rather, it attends to the intergenerational hypothesis. The code and grid system from Part B in SAIR is used to explore questions about this hypothesis using **type of abuse** (physical, sexual, emotional, neglect, alcohol, drugs) to cross-tabulate **relationship of offender and victim** (grandmother, grandfather) and (mother, father). **Type of abuse** is also cross-tabulated with **disability** (nondisabled and 102 persons with disabilties) as an example of exploring differences in the genograms of target populations.

Tables 10 through 15 show that the victim's grandparents were offenders of various types of abuse. Tables 16 through 19 show that the victims' parents were often the target of that SA. In response to whether a particular type of abuse by the grandfather would be more significant than the grandmother, a chi square analysis of a comparison of offending grandparents with type of abuse was run. Results are shown in Table 53. A comparison of the distributions of whether the child's mother or father was the victim follows in Table 54. Finally, Table 55 compares significant differences in distributions for the populations with and without disabilities and type of abuse in the genogram .

Table 53

Type of Abuse X Offending Grandparents

Type of Abuse	(N)	Grandfather	Grandmother	*p* value
Physical	180	138 (76.7)	42 (23.3)	*p*<.04
Sexual	118	110 (93.2)	8 (6.8)	*p*<.001
Neglect	32	11 (34.4)	21 (65.6)	*p*<.001
Emotional	155	97 (62.6)	58 (37.4)	*p*<.001
Alcohol	148	97 (65.5)	51 (34.5)	*p*<.04
Drugs	7	4 (.6)	3 (.4)	

It can be seen in Table 53 that in all but one type of abuse the significant difference in distributions is in the direction of the grandfather. The one exception is the area of neglect, where grandmothers appear more likely to use this type of abuse tactic. This supports the intergenerational hypothesis.

Table 54

Type of Genogram Abuse X Parent as Victim

Type of Abuse	Frequency	Mother	Father	*p* value
Sexual	205	14 (6.8)	191 (93.2)	*p*<.02
Emotional	179	27 (15.1)	152 (84.9)	*p*<.001

Both significant differences in distributions of sexual and emotional abuse are in the direction of the mother as victim. This finding also supports the intergenerational hypothesis.

A general comparison of historical abuse between the 102 clients with disabilties and clients without disabilities is shown below in Table 55.

Table 55

Type of Historical Abuse X Disability Group (Disability or No Disabilitiy)

Type of Abuse	(N)	No Disability	102 Disabled	*p* value
Physical	510	384 (33.5)	126 (43.8)	$p<.001$
Sexual	431	364 (31.8)	67 (23.3)	$p<.005$
Emotional	483	360 (31.4)	123 (42.7)	$p<.001$
Alcohol	455	338 (29.5)	117 (40.6)	$p<.001$
Drugs	126	109 (9.5)	17 (5.9)	$p<.05$

Table 55 shows five of the possible six types of historical abuse as having significant differences in their distributions between all those included in the sample with disabilities and those without disabilities. The direction is split. The total population of disabled are more likely to have PA, EA, and abuse of alcohol. The non-disabled tended to lean toward SA and drug abuse.

Table 56 shows a similar pattern when the non-disabled distributions were compared to the program disabled. The same two categories (SA and Drugs) were significant for the non-disabled, as was the PA category for the program disabled. However, this time neglect was also significant for this group, but emotional and alcohol types of abuse were not significantly different from the non-disabled.

Table 56

Type of Historical Abuse X Disability Group
(Program Disability or No Disabilitiy)

Type of Abuse	Frequency	No Disability	51 Program	*p* value
Physical	414	354 (33.5)	60 (53.6)	*p*<.001
Sexual	367	345 (32)	22 (19.6)	*p*<.007
Emotional	379	335 (31.1)	44 (39.3)	*p*<.08
Neglect	129	99 (9.2)	30 (26.8)	*p*<.001
Alcohol	361	319 (29.6)	42 (37.5)	*p*<.08
Drugs	104	109 (9.7)	4 (3.6)	*p*<.03

Summary of Chi Square Tests of Independence

Herein ends the chi square analysis for some of the data collected during Phase Two of the development of SAIR. Several items were compared for two major themes in the literature on CSA: the trauma continuum and the intergenerational hypothesis. A brief summary follows:

Two major reviews of results from studies (Asher, 1988; Brown & Finkelhor, 1986) provide strong support that the degree of post traumatic stress syndrome (PTSD) following CSA may be significantly related to mediating internal and external factors. Examples of mediating internal resources are degrees of personality attributes such as contentment or complacency, intellect, physical ability, and emotional stability at the time of observation. Examples of external resources mediating CSA trauma are support from friends and family, professional response, and sympathetic sex partners.

One of the purposes in the development of SAIR was to test the validity of the items generated. The data collected in Phase Two of SAIR's development could also be used for research (i.e., to compare the results with other research literature). Therefore, two major themes (trauma and intergenerational hypotheses) were chosen as examples of questions and answers that can be determined for those who wish to do CSA or target group research.

Regarding the trauma continuum hypothesis, chi square analysis compared the distributions of variable categories by each of the 133 individual items of sequelae, and then again by the seven groups of sequelae. The six variable distributions compared are: 1) relationship of offender to victim; 2) number of offenders; 3) number of times abuse occurred; 4) degree of intrusiveness (Type of SA); 5) concurrent physical, emotional, or neglectful abuse; and 6) duration of abuse.

A second set of chi square tables was summarized as a comparison of two levels of mental or physical disability with individual and group sequelae. The 102 individuals categorized as having at least one disability and those 51 disabled who were in a counselling program specially funded by the B.C. Government (program disabled) were crossed with the 350 files of those who were nondisabled. In addition to the disabled population, the Aboriginal population in the sample (*n*=60) was compared by sequelae items and groups. Third, gender comparisons of each sequelae item and sequelae groups were compared for significant differences in distributions.

The second theme chosen for investigation with SAIR items and sample files concerns the intergenerational hypothesis. Two special populations (all 102 who reported any type of disability, 51 people in the special program for the disabled) were compared separately with the distributions found in the nondisabled populations for type of abuse used by offending grandparents and experienced by parent victims. A summary of findings for both themes are provided below and discussed in Chapter Five.

Summary of Findings Cited in Chapter Four

Chapter Four has provided the frequency counts and percentages for each SAIR item for all 452 files where a positive response (presence of that information) occurrred. It also has provided results from chi square analysis using the frequency data to compare items and target groups on two major hypotheses in CSA (i.e., the trauma continuum and intergenerational abuse).

The primary purpose of this thesis was to design and test items for SAIR. In this process, a large amount of SAIR data provided details regarding the clientele at VCSAS. The purpose for analyzing the data is two fold: Primarily, it is an attempt to establish some degree of construct validity to SAIR items by comparing the findings with those found in the literature. In addition to frequency counts, chi square analyses allows differences among groups to be determined. Results suggest the instrument is sensitive enough to determine differences among its items and categories. A secondary purpose is to determine the domain of phenomena associated with CSA among the clientel at VCSAS. Therefore, basic descriptive facts of the population have been provided by frequency counts and proportional percentages throughout this chapter. Valid percentages are given for items based on a positive response to a category whenever actual percentages were unavailable. Results are shown in Tables 2 through 41. In addition, and in order to show that SAIR can be used as a reliable and valid research tool, two major issues in the CSA literature are explored through cross-tabulations of items and groups: hypotheses related to the trauma continuum and the intergenerational hypothesis. Results are shown in Tables 42 through 55.

There are many questions that could be asked of the data that are beyond the scope of this thesis. More research is currently being carried out by the SA and Disabilities Project at the University of Alberta (see Appendix E). In order to avoid redundancy of repeating data at the end of this chapter and again in Chapter Five, a brief summary and discussion of findings worth highlighting for both sections of the analysis (frequency counts and chi square) are encapsulated in the Discussion Chapter of this thesis.

Chapter Five
DISCUSSION

Introduction

The purpose of SAIR was to develop an efficient tool for the professional concerned with CSA or disabled adults for four purposes: (1) ongoing research into phenomena associated with SA, (2) as an assessment tool for treatment, (3) as a record of accountability, and (4) as a plausible means of providing a realistic account of the incidence and prevalence of CSA among different target populations. The credibility of each of these four claims is assessed at the end of this chapter.

The development of SAIR progressed in three phases: Phase One required familiarization with the literature on CSA including adult issues such as retrieval of memories by adults who allege SA as a child, increased vulnerability of the those with disabilities, increasing reports of CSA by adult males, and special concerns for Natives who come from dually affected families (i.e., families where alcoholism and sexual abuse are concurrent). Following this step, the framework of SAIR was designed with four parts: Part A: Victim Demographics; Part B: History of Abuse in the Family Genogram; Part C: Offender Demographics, Incidents, and Reporting Procedures; and Part D: Victim Sequelae. In addition, major constructs were mapped out (e.g., classification of relationship to victim, type of sexual abuse).

Phase Two of the development of SAIR required that the items generated in Phase One be tested on a sample of victims of CSA. The Victoria Child Sexual Abuse Society (VCSAS) provided the files of 452 clients who either were currently receiving, or had previously received, counselling. New items were generated and others were refined through consultation with the counsellors of the victims whose files provided the data. Phase Three involved a further refinement to SAIR items due to coding requirements for the computer program (SPSSx, 1988) at the University of Alberta. Further consultation was provided by professional colleagues, some of whom attended a conference for disabililites, and offered suggestions for additional items.

The primary purpose of this thesis was the development of SAIR. In the process of generating and refining items, SAIR was used to collect data on victims of SA. While a thorough analysis of these data is a secondary purpose of the thesis, basic descriptive statistics are provided. Frequency counts and percentages are given for every item in SAIR. In addition, two major themes (trauma continuum and intergenerational hypothesis) are explored using chi square tests of independence on various items cross-tabulated with target group categories. The reason for the inclusion of these data in this thesis is to determine some degree of construct validity related to SAIR items. One way construct validity is determined is through statistical correlations with other instruments purporting to measure the same or different construct. No formal statistical analysis of SAIR item validity was determined for this thesis. However, convergent and divergent findings from those findings cited in the Review of Literature Chapter of this thesis provide some degree of construct validity. Therefore, a summary of salient findings and their possible implications relating to both clinical issues and the construction of SAIR are discussed in this chapter. In order to remain consistent with the format of SAIR and the approach presented in Chapter Four, these highlights will begin with Part A (Victim Demographics), then Parts B, C, and D, with a follow-up discussion about the chi square analyses.

Highlights of Findings From Data Collected During Phase Two in the Development of SAIR

Part A (Victim Demographics):

There were 452 files of victims reporting 689 offenders. The sample was divided into three target groups: 102 files of victims with any type of disability (Disability), 51 of the 102 files with disabilities were victims who were in a special needs counselling program (PD), and 60 files of individuals with Aboriginal descent

(Native). Dividing the sample into target groups provides a better assessment of SAIR as a valid instrument because it allows for the possibility of distinctions to be determined among groups on certain constructs. Based on this sample, SAIR indicates the current status of clients at VCSAS indicate the following:

* Almost 90% of referrals come from child welfare as opposed to coming directly from the victim or parent(s). This finding is likely to be a reflection of the agency's funding policies (e.g., social services, mental health) rather than a true indicator of referral sources for CSA victims. Three of the nine items were not endorsed (church, medical professional, and other). As a researcher, I might be inclined to throw out these items but as a clinician, it makes sense that these categories are feasible choices given either a different set of files at VCSAS or a different population to sample.

* One fifth of the sample is handicapped with a ratio of 4 to 1 with a mental or physical disabilitiy, respectively. Approximately one seventh is Native. This finding suggests that CSA is a pervasive act of violence across intellectual or physical disabilitiy as well as across race. These target groups can be used to distinguish differences on SAIR items, thereby suggesting an instrument that is senstive to determine differences among groups.

* The mean number of offenders is 1.5 per victim with most (72%) having one offender and more than one fourth having 2 or more. This supports the literature that a significant proportion of SA victims are revictimized throughout their lifetimes (Brier, 1984; Herman, 1991; Peterson and Seligman, 1983; & Porter, 1986). It also validates the structure of SAIR which allows for additional Part C's depending on the number of offenders the victim alleges to have experienced.

* The mean age of the victim at the time of the first sexual encounter is 7 years, at the last sexual encounter is 9.5 years, and

at counselling, 12 years. Those with disabilities do all these things 2 to 3 years later than those without disabilities. This finding from SAIR data suggests a relationship may exist between mental or physical ability and first sexual encounter. It also points to the validity of these three SAIR items in that the age of victims with disabilities can be distinguished from those who are not disabled.

* The mean age range of victims experiencing SA is 1 to 45. This age range suggests that adult survivors of CSA or sexual abuse of the disabled may require counselling anytime throughout adulthood. This finding supports the studies that reveal symptoms of trauma may be triggered long after their initial impact and appear unexpectedly during certain phases or events (e.g., the SA of a child stirs up memories of a mother's own sexual victimization as a child). Certainly, researchers such as Sgroi (1988) provide numerous examples of adult "survivors" who continue to experience the long-term effects of sexual abuse.

* Mean duration of abuse is 2.5 years which is approximately 1 year less than Disability or Native groups. (Natives have the longest duration of abuse). This finding indicates there may be a relationship to a specific target group and duration of abuse. Perhaps there are reasons that those who are disabled or Native have a more difficult time disclosing their abuse or securing counselling services. SAIR could be used in different populations for further data collection on this item to determine if there are patterns that prevent these target groups from terminating their abuse at the same time as those who do not belong to one of these target groups.

This finding also suggests these items on SAIR are able to distinguish differences among groups, which is one of the purposes in developing SAIR. It would be interesting to compare gender and duration for target groups to determine whether differences still exist when gender is controlled.

* The ratio of females to males for everyone is 3 to 1, respectively. The disabled tend to have a lower ratio (2 to 1), although in the same direction as nondisabled and Natives. This finding supports the literature that more females report CSA than do males (e.g., Finkelhor, 1987). The proportions of male clients and female clients attending counselling at VCSAS can be compared to the number of males and females in the survey sample conducted by the1984 Badgley Commission. The Badgley report is thought to have exposed a high percentage of CSA among males due to the fact that its information was obtained by a survey of retrospective accounts of CSA by adults. The proportions of female victims of CSA are similar: Badgley reports two thirds of the sample as female (63%), VCSAS reports three fourths as female (75%). However, an interesting phenomenon occurs with the proportion of males: Badgley's survey sample consisted of one third (38%) males who had been SA. This proportion is similar to that found in the targeted 102 disabled population (33%), however, the proportion of males for the entire sample (452) is only one fourth (25%). These findings suggest that gender and disability are related to discovery or disclosure of SA. One hypothesis to explore is that the SA of disabled males is revealed more often than SA by nondisabled males. It may be that males who are SA and disabled are somehow more prone to being discovered. The distinction among males in different target groups on this item lends credibility to the sensitivity of this SAIR item.

* Only one fourth (26%) of SA is terminated due to direct disclosure from the victim or someone else. Most often the abuse is abated either because the victim moves away or avoids the offender, or the offender loses interest, changes proximity, or is removed from access to the victim. This finding supports the literature that states children do not tell of their abuse usually due to fear, shame, or some aspect related to the grooming process. Rather, they may deliberately or inadvertenlty disclose through their behavior and symptomatology. (e.g., Gomes-Schwartz, Horowitz, &

Sauzier, 1985). This finding supports the large inclusion of sequelae items included in Part D of SAIR.

* As expected, most (63%) of the disclosures of SA by clients at VCSAS occur prior to counselling. However, approximately 10% occur during counselling. This finding supports what many clinicians experience. That is, children or their parents (usually mothers) disclose additional SA once they become more trusting of the counsellor and counselling situation.

* Blended families are a common part of the sexual abuse victim population. Almost one third (29%) of male clients and one fourth (23%) of female clients have half siblings (i.e., siblings have one biological parent in common) or step siblings (no genetic relationship). Statistics tell us that divorce rates in North America are on the increase and blended families are an inevitable result of new partnerships. Therefore, it is difficult to know whether this phenomenon is significant to sexual abuse. It would be interesting to compare these proportions with other types of populations. For instance, do athletes have a similar proportion of blended families?

* Relationships within families can be transient in modern times. For this study, 2 years was set as the criterion before a relationship was considered within the family situation e.g., step sibling). An examination of these blended relationships reveals the eldest child was the victim of SA about half of the time (55%), the youngest, one third of the time (30.8%), and the middle child was the least likely victim (13.7%). These results indicate the eldest child to be the victim most of the time, but suggest that incest is not limited to the eldest child, or just one child. These categories for birth order on SAIR appear to be sensitive to differences in groups.

It would be interesting to determine if this pervasive incest was concurrent among siblings or if it graduated from the eldest to the youngest as is often the case in pedophilia. Groth (1979a) provides his theory on types of offenders. These could be used as categories for research in comparison with sibling birth order.

* There does not appear to be any difference in the parents' relationship status while the SA was occurring as about one half (53%) occurred in the home where no stable mate was acknowledged and one half (47%) occurred in situations where the parents were married or living common law. This finding also supports the validity of SAIR as a tool for data collection and research as I am not aware of the parents' relationship status presented as an issue in the literature.

* Ritual cult abuse was acknowledged in 2% of the cases. This finding supports the hypothesis that ritual cult abuse may be reasonably suspected or alleged in a very small minority of CSA cases. It is interesting to note that the 8 cases came from a number of different counsellors. Certainly, I would be suspicious of a counsellor's credibility if most or all of the cases came from him/her. It would indicate to me that the counsellor was projecting his/her own ideas into his/her counselling situation - a danger currently addressed through the false memory syndrome debate.

SAIR could be used as a supervisory tool in this sense. Pertinent items of concern could be monitored by a counsellor's response to SAIR items of a number of clients. Another useful way to benefit from monitoring particular items on SAIR is to balance a caseload better amongst staff (e.g., even distribution of clients by gender, disability, particular age group, or type of sequelae).

Part B: (Abuse in the Family Genogram)

* Results also show that abuse in the victim's family history is a common occurrence. Files indicated 1433 separate incidents as a bare minimal amount (i.e., each offender-victim relationship was recorded once, rather than recording the number of actual abusive incidents). Three fourths of the file sample (76%) reported some

type of six kinds of abuse in the family map. These findings show that SAIR can produce a large volume of data in a very efficient manner. Using the grid designed in Part B for relationship of offender to victim and type of abuse is a handy way to explore patterns in the family map. As a clinician, I enjoy working with the genogram as part of the treatment process in some of my cases. Some clients are able to recognize patterns which then assists them in their resolve to break the negative patterns they often have acquired as children.

It is important to note that many files contained information about the genogram as given by the client or the client's mother. Thus, there is likely a bias in the data in that females would tend to know more about abuse in their own family history than that of the child's father's genogram history. Therefore, the files may contain information about the victimizatiion of females more than that of males. It would be interesting to try SAIR out on a population of male victims to see if their was a distinction in the findings for each category of alleged offender to victim abuse in the genogram.

* Of those offending relatives whose gender was recorded, roughly two thirds were males (68%) and one third were females (32%). This finding supports the patriarchial society position upheld by the feminist movement: males tend to be perpetrators of abuse and females tend to be victims. However, there is a good portion of female offenders as well. Highlights of each type of abuse by offending relative is summarized:

* **Physical abuse:** Approximately one third of all clients (36%) had relatives alleged to be physically abusive. Three fourths (75%) were males with fathers comprising one third of this proportion, and grandfathers, one fourth. This finding bears discussion regarding the changing perception of what constitutes physical abuse. Today, discipline by spanking is seen as abusive by some; certainly, "the strap" has gone by the wayside from schools. Training to understand the meaning

of these constructs would be required before SAIR is implemented by a counsellor or other professional.

* **Sexual abuse:** About one third of all clients (30%) had relatives alleged to be sexually abusive, the vast majority were male (71%). Results suggest it was not the father who was the main perpetrator, rather one fourth (27%) were other male relatives (e.g., brother, uncle) and one fourth (25%) were grandfathers. Perhaps too much focus in the research literature is placed in favor of father-daughter incest rather than by other male relatives. Researchers such as Gilgun (1984) do not believe in the "myth" of the collusive mother. She found that father-daughter incest represents less than one quarter of all incest offences. This convergent finding (one eighth of alleged offenders in the genogram were fathers) supports SAIR as a valid tool for collecting data from the genogram.

* **Neglect:** One tenth of all clients (10%) had relatives alleged to be neglectful. Contrary to other types of abuse, female and male relative offenders comprise similar proportions (four tenths) of offenders. One fourth of these were mothers and one fourth were fathers. Although neglect rated the lowest in terms of abuse by relatives, it is interesting to note that females are reported equal to males. The intergenerational hypothesis suggests that mothers are perceived as neglectful because they are unable to cope with their own CSA issues, and therefore cannot provide the nurturing required by their eldest daughters.

* **Emotional abuse:** Approximately one third of all clients (34%) had relatives alleged to be emotionally or verbally abusive. About half of these were male (56%) and one third were female (38%). This type of abuse was pervasive not only through gender, but also through generations (parents, 52% and grandparents, 38%). Lower percentages for

grandparents may simply reflect less knowledge by clients about their grandparents' personal habits and emotional response rather than an actual reduced prevalence of EA in the older generation.

* **Alcohol abuse**: Approximately one third of all clients (32%) had relatives alleged to abuse alcohol. More than half of these were male (58%), and two fifths were female (40%). In addition to gender, these proportions were spread out fairly evenly through generations of parents and grandparents. It appears there may be a strong intergenerational linkage in families dually affected by alcoholism and sexual abuse. This finding is not surprising to most clinicians who counsel victims of abuse who have alcohol as an additional self abuse problem.

* **Drug abuse**: About one tenth (10%) of the clients had relatives alleged to abuse drugs. Females and males had almost equal proportions (50% and 46%, respectively). It would be interesting to compare this percentage with the percentage of drug abusers in the general population or, as mentioned above, with other populations, such as athletes.

* File victims also had 985 reported incidents of victims among their relatives for PA, SA, EA, and neglect. Of the responses given for each category, females received the greatest proportion of abuse. Mothers and other female relatives comprised most of this proportion (41%). This again supports the hypothesis that males tend to be offenders and females tend to be victims.

* Actual percentages for each type of victimization can be seen in Tables 16-19. File data provides proportions of offenders among clients' relatives:

* **Family victim of physical abuse**: Two thirds were females (63%) and one fifth were males (19%). Mothers accounted for the largest percentage (43%) with other female

relatives and other male relatives experiencing PA equally (14%). While the proportion of mothers of clients at VCSAS who experienced PA may be representative of some mothers of CSA victims, the mothers themselves often are the supplier of information in the files. Therefore, the fact that mothers accompany their children to counselling at VCSAS may create a bias in recording more PA for mothers than other relative categories. Males might have higher proportions of PA in their family maps should a different type of population be explored (e.g., adult males in prison). The same can be said of the other three types of abuse as well.

* **Family victim of sexual abuse:** Three fourths of the relatives who experienced SA are females (76%) and one fifth are males (17%). Mothers comprise the greatest proportion (44%) with other female relatives adding another one third (29%). Other male relatives comprised one eighth (12.5) of the reported cases. These findings support the hypothesis that large numbers of adult females are survivors of CSA, as are a significant, although much smaller, proportion of adult males. It is interesting to note the small proportion of grandmothers (1%) who are alleged to be victims of sexual abuse. Again, this finding may reflect absence of information in the file (CSA was not openly talked about until recently), rather than an actual minimal proportion of SA victims among grandmothers.

* **Family victim of neglect:** One eighth (13%) of clients at VCSAS had relatives who experienced some form of neglect. Most were females (35%) and one fifth were males (22%). Mothers reported the most neglect (19%). These findings also lend support for the intergenerational hypothesis that states the female child becomes parentified due to neglect by her mother and sexual exploitation by her father. In an effort to determine if women experience more neglect than males, mothers and fathers were crossed for type of abuse.

Discussion of findings are provided in the chi square analysis portion of this chapter.

*** Family victim of emotional or verbal abuse:** Two fifths of the victims reported relatives experiencing emotional or verbal abuse. More than half were females (56%) and one fifth were males (22%). Of the females, mothers again comprise the greatest proportion of response (38%).

Part C: (Offender Demographics and Incident Information)

One problem with the reliability of the data collected in Part C of SAIR is that information about the offender and specifics of incidents were difficult to obtain. This is logical for two reasons. First, VCSAS is for victims, not offenders, hence it is to be expected more would be known about the victim than the offender. Percentages represent proportions of the various sample sizes for each item in the questionaire. Sample sizes were always noted to avoid misinterpretation of the results. Second, many of the findings and new research theories have yet to be implemented into counselling procedures. Theories such as the intricate mechanism of the grooming process must be taught to counsellors before they are able to recognize and respond to its negative outcome (e.g., depression and guilt of victim over reporting abuser, inability to distinguish affection from sex). As in other sciences, too often theoretical findings and practice fall short of one another. Counsellors who are unaware of these new issues are unlikely to record pertinent information. Hence, there were few variable responses to these items.

Ten constructs are listed in Table 20 that provide valid percentages from data collected on less than 50% of the alleged 689 CSA offenders. However, due to the large pool of files, there were still ample data to provide valid results. However these data should be interpreted with the actual proportion in mind. Pertinent descriptive facts of the alleged offenders, SA incidents, and the reporting procedures as reported in the file sample are provided from data collected in Part C of SAIR. The purpose of reporting the data is to determine item validity.

* Almost all alleged offenders were male (92%), 8% were female. This supports the patriarchial society theory exposed by feminists, which states that we live in a society dominated by males who exploit females. However, it is becoming more known that many males do not report their abuse, some of whom are abused by females. SAIR could be used to collect data from hard to reach populations (e.g., teenage males) if it were filled out anonymously.

* Five percent of alleged offenders had some type of mental or physical disability. Specific disability could be recorded using the same chart as the victim (Part A of SAIR) if this information was determined for greater numbers of offenders in future research (i.e., with data provided after SAIR had been properly implemented for recording procedures).

* Mean age of offender when abuse of victim (VCSAS client) began was 24 years, and mean age was 27 years when SA terminated with client. The range in age of offenders was 3 to 81. This large range in offenders' age provides support for trends expressed in the Wachtel Report (1991). First, younger children are engaging in sexually acting out behavior. This behavior at such an early stage of development is usually considered an innocent reenactment of a child's own sexual victimization, rather than perpetrator behavior per se. However, the criterion (e.g., exact age or developmental level) has yet to be established for distinguishing between sexually reactive and sexually exploitive offender behavior in young children. Perhaps there are factors that are related on responses to SAIR items that may indicate hypotheses for further research on this issue (e.g., age by gender by type of SA by relationship to original offender).

On the other end of the continuum, offenders who are in their senior years support Groth's (1979a) theory on pedophiles (i.e., some pedophiles may continue to perpetrate their abuse on children throughout their entire lives).

- Almost three fourths of the offenders (70%) were classified as adults (age 20 and up), 14% were adolescents, and 17% were classified as children 12 and under. This again reinforces the trends of increasing incidence of early sexually acting out behavior (e.g., Wachtel Report, 1991).

- Mean age difference between offender and victim was 18 years with a wide age range difference from 1 to 73 years. This finding suggests age is no barrier to offenders of CSA or SA with vulnerable adults. SAIR could potentially be used to learn more about offenders if it was used with offenders themselves. Some other format (SAIR -Form B) could be designed to tap this wealth of information in various settings such as forensic counselling situations.

- Of the 681 cases where the offender was known to the victim, about three fifths (58%) were classified as extrafamilial and two fifths as intrafamilial (41%). This shows a fairly rounded heterogeneous population and also lays other stereotypical views to rest about which type of classification is more common among children. It appears CSA can occur in either situation. Intrafamilially, it was fathers, stepfathers, and other male relatives who made up the vast proportion (75%) of offenders. Extrafamilially, a smilar proportion (69%) was found in the category representing someone who is a known and trusted acquaintance. Clearly, it confirms that the abuser, even extrafamilially, is not a stranger to the victim.

- Furthermore, considering that most of the offending relationships evolved past a one time occurrence (73%) and that one half (51%) of the SA experiences were of the highest degree of intrusiveness, the offender and victim appear to be psychologically interlocked in some sort of insidious process where trust is violated, yet abuse continues to be perpetrated beyond a single occurrence, which in some cases, goes on for many years. Such long-term cases are explained by the intergenerational hypothesis: many women continue to expose themselves to abusive males as they are either unable to distinguish between sexual abuse and sexual affection, or because they believe they deserve to be abused.

* One half of the offenders (50%) were single and about one half (46%) were married or living common law. However, this finding must be interpreted with caution as it was based on less than half the actual incidence of offenders.

* Only one fifth of the total number of offenders were known to receive either a punitive or rehabilitative sentence from the courts. There are two factors that may be contributing to the low response rate for the outcome of investigation items. The first is the generally sparse information contained in the files on this construct due to little focus on collecting offender data. The second factor that may be contributing to low response rate is that the justice system is a long, slow process, and often, children wait for months before the process is finally over. Therefore, the final outcome of a trial may not be known at the time counselling is terminated. Because the file is not reopened, the information is rarely noted. If a file was not closed until SAIR was completed, it might help to acquire this valuable research information.

Part D: (Sequelae)

Each item on the sequelae section of SAIR received a response that was tabled from highest to lowest frequency for convenience of interpretation. Similar items within each grouping were noted and actual percentages calculated for the entire sample as a way of ascertaining the proportion of response for each item.

* All but five victims had at least one response to a sequelae item. The mean number of 133 sequelae items per victim was 15, median 13, range 0 to 69. Frequency response for each item ranged from 2 (Excessive problems with menses) to 196 (Displays dominant or aggressive behavior toward others). Table 29 provides the frequencies of response for sequelae items within their seven groupings. A response was coded for one of the seven sequelae groups when one or more sequelae items within the group was recorded per victim. Actual percentages are provided for difficulties experienced per victim in each sequelae group:

  * Behavioral and emotional response, (93%).
  * Personal relationships, (80%)
  * Sexuality, (60%)
  * School, Work or Social Performance, (56%)
  * Bedtime, (49%)
  * Medical or Somatic Complaints, (29%)
  * Hygiene, (17%)
  * No sequelae, (1%)

The frequencies for 133 items will not be repeated here as they were provided in Chapter Four. Instead, sequelae groups and items are discussed in detail through chi square analysis in the second part of this chapter.

Findings and Implications for Chi Square Tests of Independence

As stated at the beginning of Chaper Four, a conceptual approach was undertaken in the selection of the variables for chi square analysis. The rationale behind this approach was to provide some measure of construct validity for the SAIR items and their categories when compared with convergent and divergent findings in the literature. Issues were selected which had received some significant research results in one direction in the literature (e.g., trauma as related to duration of abuse, number of incidents, degree of intrusiveness, or concurrent abuse). Other issues were chosen as pioneer issues (e.g., target populations of disabled and Natives as compared to the rest of the sample or differences in gender issues which may have been previously surmised, but little researched).

The second part of this approach to the discussion of results concerns how some of the findings using SAIR relate to other research findings as discussed in the literature review. Assuming SAIR sequelae are a valid representation of the outcome of trauma associated with CSA, several questions can be asked in relation to some of the variable categories that might be associated with the trauma. These questions are posed below:

Does the relationship between the offender and victim make any difference in sequelae?

The literature suggests that incestuous experiences are more traumatic than extrafamilial experiences because a child's basic trust of close family members is broken. Little or no research addresses the issue of victims who suffer abuse from both categories. As mentioned in the 13 principles of abuse, it used to be assumed that a pedophile within the family stayed there, but it is now known this is not the case. Many offenders move back and forth across categories. When all sequelae groups were compared with victims who suffered either intrafamilial or extrafamilial abuse, as well as those who suffered both types of SA, two groups stood out as significantly different in the direction of victims experiencing both. These victims experienced greater difficulty with their sexuality and with medical or somatic complaints. These results provide confirmation of the findings of Briere and Runtz (1990), who suggest a possible SA syndrome regarding sexual problems versus aggression as a result of PA and low self-esteem as a result of neglect. Medical and/or somatic complaints may indicate children have a harder time talking about their abuse and therefore display their feelings through body signals. Also, because they have to keep "the secret," they may not be able to tell because they fear the consequences of their disclosure. These results also lend support for this hypothesis (i.e., a child may consciously or unconsciously express fear, anger, tension through bodily malfunctions).

When individual items of sequelae were compared, all of the 29 significant items were in the direction of both categories except for an inability or unwillingness to discuss personal feelings, which is in the direction of intrafamilial abuse. This may be because there is more confusion of the victims' emotions toward the offender or strong fears over the possible family consequences following disclosure. It also suggests that many children who are exposed to both categories of abuse may experience a greater sense of helplessness, despair, anger, and various other emotions. These children may feel as though there is nowhere to escape the SA, neither inside the home nor outside of it. These pent-up feelings are then expressed consciously and unconsciously as notable sequelae.

Does the number of offenders make any difference to trauma outcome?

The question arises as to whether the large number of significant differences in distributions may be affected by other factors. Perhaps the difference may not be so much the classification of groups themselves as the impact of the number of offenders. Someone who has experienced both intrafamilial and extrafamilial abuse may have had more offenders than someone who was SA in just one category. Checking out this hypothesis meant comparing those victims who reported one offender and those who were abused by more than one offender.

A comparison of the results of both major groupings and individual sequelae found no single significant difference in any of the distributions. This interesting phenomenon appears to indicate that quantity of offenders is not a significant factor in sequelae outcome. Therefore, it can never be assumed that a child who has one offender is likely to be less traumatized than someone who has had more than one offender.

If those victims who received both types of abuse were excluded in the comparison, is either intrafamilial or extrafamilial abuse more traumatic?

The only significant grouping was school/work/social in direction of extrafamilial. These results may suggest "masking" of behaviors. Children who are in homes where incest is a common occurrence are often passed over as their symptoms of trauma are: a) difficult to distinguish from other dysfunctional family patterns, and therefore, professionals may not notice to report; b) the child may learn to live and adjust better; c) the child may be more fearful of disclosure or discovery and so attempt to cope by adapting to the situation. Finkelhor (1986) feels it is necessary to use caution when attempting to distinguish the traumatic outcome of intrafamilial abuse: "Some kinds of sexual abuse may be so integrally related to deep and long-standing family patterns that it may never be possible to disentangle the effects of abuse from some of its antecedents" (p. 212).

These results may also suggest that children who are SA outside the home and have received support and attention from parents have their trauma exacerbated because of the combined reaction from their family members, often called "secondary" victims. Children often report they feel somehow different from others who have not been SA. These children may be consciously or unconsciously expressing their need for attention and support from others more overtly in their daily routines. This hypothesis is further indicated by the results of the individual sequelae items where it was shown that many items came from this emotional/behavioral grouping.

Eleven out of 14 significant differences in distributions come from intrafamilial category. However, a closer inspection shows that most of these differences have to do with a particular type of sequelae (i.e., behavioral/emotional symptoms such as depression, self-abuse, or dissociative episodes. This bears more consideration as there may be very specific sequelae syndromes for specific categories of CSA.

Taken together, the distinction between the two groups was evenly distributed among the type of sequelae with the three significant extrafamilial differences coming from three categories (daily activities, personal relationships, and hygiene) and the 11 intrafamilial differences coming from three groupings (sexuality, behavioral/emotional, and medical/somatic complaints).

In conclusion, there does not appear to be any significant overall differences in whether the individual was a victim of intrafamilail or extrafamilial abuse. Rather, it is the experience of having been a victim of both categories of abuse that is the most significant in terms of sequelae outcome.

Does repeated abuse affect the trauma outcome?

Aside from the number of offenders, a second factor that appeared to affect the distributions in favor of the "both" category is the actual number of encounters of SA experienced by the victim. Perhaps those victims who experienced SA in both categories just happen to have more incidents and, therefore, that factor might be influencing the relationship results. Certainly, this factor must be considered.

Comparing groups of sequelae, differences for personal relationships, sexuality, and medical/somatic complaints were found, all in the direction of highest category of incidents (more than 10X). Furthermore, many (41) individual sequelae have significant differences in distribution in the direction of the most repeated abuse (two for 2 to10X). Several items endorsed were severe symptoms related to substance abuse, sexual dysfunction, poor ability to relate appropriately to others, and a fair amount of dissociative episodes. Results from SAIR support the hypothesis that the number of incidents is related to the degree of trauma.

Does the degree of intrusiveness make a difference?

There were two significant differences found in the groups of sequelae: one in in sexuality and the other in school/work/social activities. Both were in the direction of the highest degree of intrusiveness. Just four individual sequelae items, two having to do with depression and suicidal ideation and two with dissociation, were significantly different, also in the direction of very intrusive abuse. Therefore, SAIR results lend some support for degree of intrusiveness. Although not a lot of items, the degree of intrusiveness is most notable. This finding is yet another example for potential investigation for future development of SAIR (i.e., what might be the criteria to distinguish degree of trauma between the *number* of sequelae items versus the *type* of sequelae item).

Does concurrent abuse have any relationship to sequelae outcome?

There were two significant groups in the direction of concurrent abuse. These were personal relationships and medical/somatic complaints. This makes logical sense because one would expect more physical evidence with PA and and poor self-esteem with EA and neglect. Likewise, a large pool of individual items (23 out of 24) were also found significant in the direction of concurent abuse. Therefore, SAIR results provide a great deal of support for the hypothesis that concurrent abuse affects sequelae outcomes.

Does duration of abuse have a relationship to sequelae outcome?

There were four significant differences in sequelae groups, all in the direction of longest duration (school/work/social, personal relationships, sexuality, and medical/somatic). Also, all but two of the 31 significant sequelae items were also in this direction. Therefore, lengthy duration appears to have a pervasive effect on the victim's life.

In conclusion, the trauma syndrome cannot be predicted by these constructs alone. Perhaps if they were factored out, interacting variables that accompany specific syndromes or mini-syndromes might emerge. For example, SAIR results suggest that it may be that CSA victims with both types of intra- and extrafamilial relationships experience greater trauma than those who experience just one category of relationship, regardless of the number of offenders. Support was found for hypotheses related to increased trauma as a result of repeated incidents, concurrent abuse, duration, and degree of intrusiveness. There was no support found for hypotheses of a relationship between the number of offenders per se and sequelae outcome or for an overall distinction in outcome and whether the abuse was intra- or extrafamilial.

Are there differences in outcome depending on the victim belonging to one of the target groups within the sample?

The two sequelae groups of sexuality and hygiene were found different for the whole sample. The disabled population (102) experienced significant differences in problems with hygiene. Results further showed all but one of 15 significant differences in individual sequelae items were in the direction of the disabled. The only item, "presents as a little adult," was in the direction of the nondisabled. This suggests people with disabilities may not have the capacity to adopt this tactic due to either mental or physical ability level. It also points out importance of reviewing the individual items for each subgroup so that target treatment interventions can be investigated and developed for specific populations.

Do the more severely recognized disabled (program disabled) have different sequelae outcome than the whole sample?

Groupwise, the same two groups regarding sexuality and hygiene were significantly different in the direction of the PD, but the program disabled had additional bedtime trauma. Of 14 differences in individual sequelae, only one was in the direction of ND, that being an inability to express feelings about SA. Since this group of people with disabilities would be most representative of populations with disabilities, it may suggest that this relatively typical sequelae response (139 of sample of 452 or 38%) is not so much of a disability per se, but one of an unwillingness to break down psychological defenses. Again, it is important to assess the differences in items within sequelae groups by the people with disabilities and normal populations to see where the differences lie as significant differences may represent prototypes of cases for treatment designs.

There were no differences found between the 60 Aboriginal clients and the rest of the sample in groupings of sequelae. There were only two significant differences in individual sequelae: one in direction of Aboriginals (sleep disorder) and one in the direction of people without disabilities (repressed memories from childhood). It is difficult to surmise what any of these results mean as the research is so new in this field. Perhaps non-Natives are more willing to admit they have memory gaps, but Native people may not talk about it so much.

Does gender make any difference in sequelae outcome?

There were no significant differences between males and females for the general groupings of sequelae. However, there were several differences, for the individual sequelae items. Of the 40 diffferences most (31) were in the direction of females. The majority of these sequelae concern fear, eating disorders and substance abuse, and dissociation. Males tended to endorse items related to acting out sexually.

Is there support for the intergenerational hypothesis theory?

Offending grandparents and grandmothers were crossed, and significant differences were found in all 6 types of abuse, all in favor of the grandfather, except for the area of neglect. These results support the intergenerational hypothesis: many mothers complain about their own neglect/abandonment by their mothers (primary victim's grandmothers) and abuse by their fathers (primary victim's grandfather). The hypothesis states the child (primary victim's mother) became parentified at an early age and consciously or unconsciously retreated from constantly having to "give" her energy to those around her (client at VCSAS). Findings also suggest that the father (primary victim's grandfather) tend to be the most abusive parent.

On the flip side, the question could be asked as to which of the victims' parents bore the brunt of the abuse. Would it be the mother, as the intergenerational hypothesis would predict? Comparisons of group sequelae found two types of abuse were significantly different for the mothers and fathers of victims: That is, the mothers received significantly more sexual and emotional abuse than reported by fathers. But rather than totally embracing the intergenerational hypothesis, it is important to consider that the results could be biased because it is usually the mothers who accompany children to the center and, therefore, provide the genogram history. Therefore, they may not know or acknowledge the extent of the abuse that the child's father experienced when he was a child. As discussed in the literature review, men lag behind the women's movement in seeking help for abuse suffered in childhood. Therefore, retroactive accounts of CSA by men are likely to be underreported.

Is there evidence for the intergenerational hypothesis among the population with disabilities?

A comparison of the clients with disabilities (both total numbers and those in the program) showed that there was just as much abuse in the family genogram. However, there may be different types to target for interventions. For instance, the groups with disabilities showed significant differences in PA, EA, and abuse of alcohol, whereas the group without disabilities tended to lean to SA and drug abuse. Since there was a significant difference in the sexuality group for the nondisabled, it may suggest that the intergenerational hypothesis is not as operative in general for families of people with disabilities. However, issues surrounding other types of abuse may be more pertinent to clients with disabilities. For example, significant differences in PA may have led to the victim's disability, or reflect the frustration of having a handicap oneself or living with someone who does. Or SA may be a more discreet type of abuse and the handicapped victim may not have the awareness to report the SA. Certainly, it is not surprising to find that those who are most disabled experience EA and neglect.

Conclusion: Current and Future Considerations in the Development of SAIR

As stated periodically throughout this thesis, the purpose of this study was to develop the Sexual Abuse Information Record (SAIR). This process took three phases, one of which required the collection of data from 452 files of victims of CSA (or adult victims abuse of the handicapped) at the Victoria Child Sexual Abuse Society (VCSAS). A secondary purpose of this thesis was to analyze the data collected from the files in order to provide some degree of construct validity for SAIR. This analysis was provided in the form of frequency counts with actual or valid percentages also being given for each item on all four parts of SAIR (Part A: Victim Demographics; Part B: Abuse in the Family Genogram; Part C: Offender Demographics, Incidents, and Reporting Procedures; and Part D: Victim Sequelae). Where possible, the findings were related to the literature on CSA in order to support convergent or divergent validity. A second set of analyses was completed using chi square tests of independence for various item categories and target groups from the file sample. Two major issues in the literature on CSA were explored: the trauma continuum and the intergenerational hypothesis. Using target groups from the file data provided differentiation among items which also supports SAIR as a senstive instrument. A summary of pertinent findings and a discussion about possible implications was provided in this chapter.

SAIR is designed to be a handy and efficient tool for any professional who is concerned or involved with victims of CSA or adult victims who are vulnerable to sexual exploitation due to thier disabilities. This thesis has made the claim that SAIR can be used for four basic purposes: (1) as a research tool, (2) as an assessment tool for the purposes of treatment intervention, (3) as a record of accountability, and (4) as an instrument that may be more suited to collect data from difficult target groiups, thereby increasing the reliability of CSA prevalence reports. The credibility of each claim is addressed as a conclusion for this thesis.

SAIR as a Research Tool:

SAIR can collect some anecdotal data, but it is primarily designed to collect nominal data determined from positive response (yes versus no) to hundreds of items subsumed under the umbrella of almost 150 constructs. There are limitations to possibilities of analysis with categorical data. However, the data collected in Phase Two of the development of SAIR can be used to describe statistical percentages representing proportions for frequency distributions of item response. This allows for a basic description of the population of clients at VCSAS. To this end, SAIR meets its purpose. Any professional individual or agency can use SAIR for a similar purpose (e.g., social worker, sex crimes investigator, school counsellor, psychiatrist or psychologist).

The research on CSA and SA of the disabled is a relatively new field. Additional research on SAIR response frequency data can provide possibilities for exploring existing or generating new hypotheses regarding the relationships among item or target group categories. Several hypotheses in the literature were supported and more explored through the chi square analysis portion of this chapter. Many findings from the two types of analyses used for data collected in SAIR concur with those found among hypotheses in the literature (e.g., factors likely contributing to intergenerational abuse, number of incidents of SA and resulting trauma).

A main consideration for this researcher in designing SAIR was to set out a prototype record for collecting and recording data consistently. As a newly devised and implemented information form on issues related to CSA or to SA of handicapped adults, SAIR appears to stand up well to its claim as a simple instrument that can be used effectively as a limited research tool.

SAIR as an Assessment Tool

By covering a wide range of phenomena associated with CSA and SA of adults with disabiltiies, SAIR provides the clinician with ample opportunity to collect relevant information pertaining to the SA of the client. No instrument can provide a complete assessment of a client, but it can *contribute* to the assessment process. (i.e., personal interview, interviews with significant others, clinical presentation). Likewise, SAIR is meant to be an adjunct to a proper and reliable assessment.

An important consideration in the use of SAIR as an assessment tool is that there is little to no evidence to support any specific effect CSA will have on an individual victim. The effects of trauma range on a continuum from little or no trauma experienced to irreparable damage. Each person responds differently to CSA because there are so many mediating factors (i.e., internal and external resources). However, it cannot be determined *how* or*when* symptoms may surface. One advantage to SAIR is that it can be kept in the file and a running account of sequelae as they appear or dissipate can be recorded. Depending on the clinical presentation at the time, a counsellor can determine appropriate intervention (e.g., self esteem, personal safety skills, assertiveness training, anger management, behavioral desensitization for phobias, and so on).

SAIR as a Record of Accountability:

SAIR consists of a wide array of items that can be used to provide a descriptive study of any aspect of CSA. In addition, there is space allowance for a more specific response on many items that provide the opportunity to *specify* or *explain.* Additional space is provided on the back cover to make anecdotal notes. Once the professional becomes familiar with items in SAIR, its consistent categories and easy recording format (primarily checks of items) make it an efficient tool for accessing factual information. Furthermore, SAIR is designed in a booklet format to keep the information concise and organized. There may be situations where only parts of SAIR may be desired (e.g., an agency may simply wish to report the number and specific disability of its clientele in order to receive financial support).

One example of using SAIR as both a research instrument, and as an instrument providing accountability for funding is that of the Sexual Abuse and Disabilities Project at the University of Alberta. As explained in Chapter Three, the items in SAIR have undergone extensive revisions throughout the research process and continue to be revised. By now, there have been an additional 200 variables created for the purposes of computer input and analysis of the data. These will not be included as items in SAIR, but are used for clarifying items and their relationships with each other. New variables continue to be created to determine characteristics of the clientele with disabilities. As new information is generated, additional funding becomes available. Professor R. Sobsey, Director of the SA and Disabilities research team, intends to use the data to compare results of the SA and disabled population internationally. Dr. Sobsey has posed a number of hypotheses regarding the outcome of SAIR data and the individuals with disabilities from the sample at VCSAS. These hypotheses can be seen in Appendix E.

SAIR as a Reliable Measure of the Prevalence of Types of SA

This last claim for SAIR has yet to be determined. For now, it can only be said that SAIR is designed to be a handy and efficient instrument for collecting details surrounding the incidents of a case of CSA or certain adult cases of SA. Some of the features of SAIR that are attractive is its booklet form that can be filled out anonymously or with the aid of someone. It can also be completed fairly quickly (about 30 minutes on average) or completed in stages (e.g., in the four parts, A, B, C, & D, or as new information is disclosed). Therefore, SAIR is expected to be equally attractive as a recording instrument for both client (or parent/guardian) and clinician or other professional.

Much of SAIR's success will have to be generated by its promotion among potential users. In addition to those who come to professionals or agencys for counselling, there are many individuals who never receive counselling, even when they need it. Thus, a true measure of the prevalence of CSA is unknown. It would be advantageous to use SAIR among target groups to gather information that otherwise goes unrecorded. One example is adolescent male victims of CSA who turn to substance abuse rather than counselling. In cases like these, SAIR could be provided to outreach workers who are in contact with target groups normally term "street" people.

Ideally, in order to reach these and other target populations which are difficult to access, SAIR would be programmed on the computer. In this way, many individuals could respond to SAIR items who might not otherwise disclose their SA to someone. This is especially true for adolescents and adult survivors who are ashamed of the stigma attached to SA or are afraid of the consequences of disclosing. Even more ideal would be the establishment of a clearing house where all data from the SAIR computer program could be continually assessed and monitored throughout a particular geographical region. A professional or agency could conveniently request and receive a printout of relevant statistical information at any time.

Finkelhor (1986) writes of some of the salient methodological issues in the field of child sexual abuse. He says:

> Sexual abuse, because of the shame and secrecy that surround it, is not an easy problem to study. The subject has been dogged by a history of myth and stereotype, and poorly designed studies in the past have only contributed to this confusion. Well-designed studies are very much needed. (p.199).

It is hoped that one well researched study may be ongoing analysis of SAIR items using a cluster analysis. Another could be placing SAIR on a computer program. Other studies could be conducted on target groups or constructs from data collected by SAIR items. Certainly, future research using SAIR is welcomed.

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APPENDIX A

The Sexual Abuse Information Record (SAIR)

Sexual Abuse Information Record (SAIR)

by

R. Moskal, PhD

Name or Code: ____________________ **Gender:** ☐ M ☐ F **Age:** ____

Address: ____

Telephone: (H) ______________ (W) ______________

Client(s) Interviewed: ☐ victim ☐ parent or guardian ☐ other

(Specify) ____

Interviewer: ____________________ **Date:** ____________

Place of Interview: ______________________________

Professional Affiliation: ______________________________

Funding:

☐ victim or family ☐ special program ☐ other

(Specify) ____

Collateral Contacts:

Medical Doctor: ________________________	phone: ____________
School: ________________________	phone: ____________
Social Worker: ________________________	phone: ____________
Other (specify): ________________________	phone: ____________
________________________	phone: ____________

This record contains four parts:

A. Victim Demographics
B. History of Abuse in Family Genogram
C. Offender Demographics, Abuse Incidents, & Reporting Procedures (repeated per number of alleged offenders)
D. Victim Sequelae

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Sexual Abuse Information Record (SAIR)

SAIR is primarily designed for use with victims of child sexual abuse (CSA). It may also be used for adult survivors of CSA or for some adults who have a mental or physical disability.

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R. Moskal, PhD
1025 Liberty Drive
Victoria, British Columbia CANADA
V9B 5B4

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Further validation research of SAIR is recommended.

Part A: Victim Demographics

REFERRAL SOURCE

File Information ID: ____________________

Referral Source:

- ☐ Self
- ☐ Police
- ☐ School
- ☐ Church
- ☐ Social Services/Child Welfare
- ☐ Professional/CommunityAgency
- ☐ Medical Professional
- ☐ Parent or Guardian (specify) ______________________________
- ☐ Other (specify) ______________________________________

Region of residence at time of abuse:

- ☐ Victoria area/Vancouver Island
- ☐ British Columbia
- ☐ Other region in Canada (specify) ___________________________
- ☐ International (specify)____________________________________

Region of residence at time of referral:

- ☐ Victoria area/Vancouver Island
- ☐ British Columbia
- ☐ Other region in Canada (specify) ___________________________
- ☐ International (specify)____________________________________

VICTIM INFORMATION

Number of alleged offenders: _____

Age:

______ (months) **Recalled age of first sexual abuse occurence**
______ (months) **Recalled age of latest sexual abuse occurence**
______ (months) **Age of client during counselling**

Disclosure or discovery situation:

- ☐ Unknown, no information
- ☐ Victim told parent or guardian (specify) ______________________
- ☐ Victim told another family member or friend
- ☐ Victim told staff member at school
- ☐ Victim told another professional outside of counselling
- ☐ Victim told during counselling
- ☐ Someone else told on/for victim
- ☐ Offender & victim discovered in sexual encounter
- ☐ Victim was sexually or behaviorally acting out on self or others
- ☐ Medical or physical evidence

Explain if techniques used to encourage disclosure:

____

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Reason abuse terminated:

☐ Unknown, no information
☐ Victim or someone else disclosed abuse
☐ Offender moved away or was removed from position/relationship
☐ Victim moved away or avoided offender
☐ Legal or professional intervention regarding child protection
☐ Offender lost interest, terminated abuse, or abuse was a single incident

Ritual cult abuse is suspected or alleged by victim:

☐ yes ☐ no ☐ uncertain

Please explain: ____
____
____

FAMILY DEMOGRAPHICS

Ethnocultural background:

☐ Caucasian
☐ Aboriginal descent
☐ South American
☐ Other (specify) ______________________
☐ Afro-American/Afro-descent
☐ Asian
☐ European

Number of siblings:

___ brothers
___ half brothers
___ stepbrothers
___ foster brothers
___ sisters
___ half sisters
___ stepsisters
___ foster sisters

Birth order of victim:

☐ youngest
☐ eldest
☐ middle
☐ unknown

Biological parents' marital status at time of abuse:

☐ married ☐ common law ☐ single
☐ separated ☐ divorced ☐ unknown

Mother's relationship status during client's counselling:

☐ married ☐ common law ☐ single
☐ separated ☐ divorced ☐ unknown

Mother's relationship status during counselling to client's biological father: ☐ same mate ☐ different mate ☐ unknown

Serial Monogamy: (three or more common law or marriage partners)
mother: ☐ yes ☐ no ☐ unknown **father:** ☐ yes ☐ no ☐ unknown

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DISABILITIES

Classification of Disability: ☐ mental disability ☐ physical disability

Specific Disability Code
(Check all that apply)

1. ☐ Auditory handicap
2. ☐ Visual handicap
3. ☐ Mobility problems
4. ☐ Neurological impairment
5. ☐ Developmentally delayed (IQ < 70)
6. ☐ Autism
7. ☐ Borderline or Low Average intelligence (IQ 70 - 89)
8. ☐ Learning disabled (e.g., dyslexia, aphasia, apraxia)
9. ☐ Attention Deficit with or without hyperactivity (ADD or ADHD)
10. ☐ Fetal alcohol syndrome or effect (FAS or FAE)
11. ☐ Psychological maladjustment (specify) ______________________
12. ☐ Other (specify) ______________________

Part B: History of Abuse in Family Genogram

(Use this code for completing Part B on the next page)

Relationship to Victim Code

0 = no offender information

Intrafamilial Relations

1 = father
2 = stepfather or father substitute
3 = mother
4 = stepmother or mother substitute
5 = grandfather or grandfather substitute
6 = grandmother or grandmother substitute
7 = other male relatives (e.g., brother, uncle, cousin, brother-in-law)
8 = other female relatives (e.g., sister, aunt, cousin, sister-in-law)
9 = other relatives (gender unknown)

Extrafamilial Relations

10 = residential position of trust or authority (e.g., caregiver, respite worker, foster parent(s), foster siblings)
11= nonresidential position of trust or authority (e.g., teacher, daycare worker, babysitter, other professional)
12= known and trusted acquaintance (e.g., neighbor, parent's mate, family friend, peer)
13= stranger

Use the number(s) from the **Relationship to Victim Code** to complete the genogram abuse table below.

Type of Abuse in Family Genogram					
Relationship (Use Relationship Code)		**Type of Abuse** (Place a checkmark in all columns that apply)			
Alleged Offender	**Victim**	**Physical**	**Sexual**	**Emotional**	**Neglect**

Addictions by significant others in family:

Use the number(s) from the **Relationship to Victim Code** to complete the substance abuse table below.

Substance Abuse in Genogram			
Alcohol	**Drugs**	**Other**	**Comments**

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Part C: Alleged Offender Demographics, Incidents, and Reporting Procedures

(Repeat Part C as per number of alleged offenders)

Offender ID# ____________________ **Gender:** ☐ M ☐ F

Victim File ID# ___________ **Total possible # of offenders** ________

Age:

____ sexual abuse began ____ sexual abuse terminated

____ Duration of abuse (approximate months)

____ Difference in age of offender and victim

Frequency of offence:

☐ once ☐ 2 to 10 times ☐ more than 10 times ☐ uncertain

Education or occupation of offender at time of abuse:

☐ preschool ☐ student ☐ college ☐ unemployed ☐ homemaker

☐ laborer ☐ blue collar ☐ paraprofessional ☐ military ☐ professional

(Specify) ____

Relationship status of offender at time of abuse:

☐ **heterosexual** ☐ **bisexual** ☐ **homosexual**

☐ single ☐ common law ☐ married ☐ separated ☐ divorced ☐ unknown

Offender had mental/physical handicap: ☐ yes ☐ no ☐ unknown

(If yes, use code from Part A for specific disability (# ___, # ___, # ___)

Offender had addictions: ☐ yes ☐ no ☐ unknown

☐ alcohol ☐ drugs ☐ other (specify) ____________________

Additional abuse tactics used by offender:

☐ physical ☐ neglect ☐ emotional/verbal (circle all that apply)

(threats, outbursts, bribes, over control, put downs)

(Explain) ____

Patterns of Abuse: ☐ yes (specify below) ☐ no pattern(s) ☐ unknown

Time:

☐ after school, weekends, casual visits ☐ during school/day care

☐ summer holidays/holiday visits/special occasion ceremonies ☐ babysitting

☐ parent(s) away from home of victim or offender (circle) ☐ bedtime/during sleep

☐ during/after a party attended by victim or offender (circle)

☐ other (specify) ____

Place:

☐ bedroom ☐ offender's home ☐ bathtub/jacuzzi ☐ vehicle ☐ hospital/medical clinic

☐ victim's home ☐ public washroom, pool, gym, sauna, change room ☐ camp or club

☐ day care or school ☐ church or affiliated building/activity ☐ park

☐ institutionalized setting ☐ other(specify) ____________________

Other Patterns:

☐ pornography ☐ grooming ☐ rituals/routines ☐ excessively religious/moralistic

☐ other (Explain) ____________________

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Criminal Investigation

Abuse alleged by: ☐ victim ☐ parent or guardian ☐ other ☐ unknown

(Specify) ____

Abuse was reported to child welfare: ☐ yes ☐ no ☐ unknown

Abuse was reported to the police: ☐ yes ☐ no ☐ unknown

Abuse was not reported because:

- ☐ victim was too frightened of consequences
- ☐ victim was discouraged from reporting by ______________________
- ☐ victim was not considered to be a credible witness due to age or ability
- ☐ victim was unable or unwilling to disclose event(s)
- ☐ offender "excused" due to age or ability or circumstances
- ☐ unknown

(Explain) ____

Charges laid against the alleged offender: ☐ yes ☐ no ☐ pending ☐ stayed ☐ investigation in progress ☐ unknown

(Explain) ____

Outcome of the Investigation

- ☐ offender sentenced to a prison term
  (specify) ______________________________________
- ☐ offender sentenced for a period of probation
  (specify) ______________________________________
- ☐ offender sentenced to receive forensic/mandatory counselling
- ☐ offender sentenced to complete community service hours
- ☐ offender received restraining order to contact victim
- ☐ diverted
- ☐ charges were dropped because victim recanted statement
- ☐ charges were dropped due to insufficient evidence
- ☐ alleged offender was acquitted

(Explain) ____

Classification of Abuse

(Use **Relationship to Victim Code** from Part B of SAIR to identify number and specify relationship) **Code #______ (specify)** ____________________

Type of Sexual Abuse

* The term "force" includes physical force, threat of physical force, or the inability to consent because of being unconscious, drugged, asleep, or in some other way which renders the victim physically helpless

____ **Very intrusive sexual abuse** (completed and attempted vaginal and/or anal intercourse, cunnilingus, fellatio; forced and unforced)

____ **Intrusive sexual abuse** (completed and attempted genital fondling, simulated intercourse, digital penetration; forced and unforced)

____ **Less intrusive sexual abuse** (completed and attempted acts of intentional sexual touching of clothed breasts, genitals, other private body areas, forced and unforced)

____ **Least intrusive sexual abuse** (no physical contact such as exhibitionism, obscene phone call or gesture, exposure to pornographic material, sexual harassment)

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Part D: Victim Sequelae

A. School, Work, and Social Activities

☐ Overly responsible: Insists on attending school/work/social activities even when ill
☐ Avoids school/work/social responsibilities
☐ Refuses to participate in some school/work/social activities
☐ Shows sudden decline in school/work/social performance
☐ Has difficulty concentrating or staying on task
☐ Is resistant to counselling (e.g., avoids appointments, is frequently late, poor insight into cause of personal problems)
☐ Extremely demanding at school/work/socially related activities
☐ Extremely withdrawn at school/work/socially relayted activities
☐ Unwillingness to undress for gym or participate in physical education activities
☐ Sexualized or bizarre art work or stories which depict themes of sexually abusive behavior (e.g., body proportions skewed, death wishes)

B. Personal Relationships

☐ Is easily led or influenced/tries hard to please others
☐ Role reversal/enmeshment with mother or father (circle one)
☐ Is very shy or withdrawn: Avoids peers/men/women (circle)
☐ Displays dominant/aggressive behavior toward others
☐ Regularly shows inappropriate emotional response to situations
☐ Has few friends
☐ Inability to establish trusting close personal relationships
☐ Repeats a pattern of engaging in abusive relationships

C. Sexuality

☐ Initiates "sexual games" with adults and/or children
☐ Touches adults/children/animals excessively or inappropriately(Circle) (Explain) ____________________
☐ Touches self excessively or inappropriately (e.g., masturbates excessively for age level, continuously fondles erogoneous zones)
☐ Shows confusion regarding his/her sexual orientation
☐ Experiences sexual dysfunction (e.g., impotency, fear of sexual intimacy, dislikes sex)
☐ Verbalizes inapppropriate "sexual" remarks, comments, jokes
☐ Preoccupied with sexual thoughts or fantasies (e.g., pornography, overly interested in doll's genitals during play)
☐ Approaches strangers inappropriately/poor sense of personal safety
☐ Uses sexuality for approval seeking from adults or children
☐ Presents as a "little adult"
☐ Dresses inappropriately: seductively or layering (Circle)
☐ Has difficulty distinguishing between affection and sexual encounters
☐ Is sexually promiscuous or has knowledge of sexual activity inappropriate for age level
☐ Has little or no age appropriate sexual knowledge

D. Bedtime

☐ Avoids going to bed or refuses to sleep alone
☐ Insists on sleeping fully clothed
☐ Sleep disorder: insomnia, hypersomnia (Circle)
☐ Refuses to sleep in bed preferring chair, floor, couch...)
☐ Keeps a weapon such as a club or knife close by bed
☐ Has nightmares or recurring dreams on a regular basis

E. Hygiene

☐ Exhibits excessive modesty surrounding bathroom or bedroom functions
☐ Is immodest, uninhibited at home or in a social situation
☐ Tries to "spy" on or intrudes on others in areas of privacy
☐ Becomes agitated during bathroom or bedroom routine(s)
☐ Appears unkempt or dirty on a regular basis
☐ Appears to be overly concerned with personal cleanliness/appearance
☐ Excessive problems with menses (e.g., obsessive fear, fascination, poor hygiene)

F. Behavioral or Emotional Symptoms

Emotional or behavioral lability:

☐ Shows a sudden behavior change
(Explain) ______________________________
☐ Appears depressed on a regular basis
☐ Makes threats about hurting self or taking own life
☐ Attempts suicide or has in past following abuse
☐ Expresses homicidal ideation towards (specify) ______________________________
(Explain) ______________________________
☐ Expresses intense anger towards (specify) ______________________________
(Explain) ______________________________
☐ Engages in impulsive behaviors with little/no regard for consequences
☐ Periodically runs away or threatens to run away

Fears/anxieties/phobic behavior:

☐ Appears unusually nervous or anxious
☐ Experiences panic attacks
☐ Experiences flashbacks of abuse
☐ Has memories or fears of choking, suffocating, stuttering (Circle)
☐ Expresses fear about losing control and becoming abusive to self or others (Circle)
☐ Displays intense fear of a specific place
(Specify) ______________________________
☐ Displays intense fear of a specific person
(Specify) ______________________________
☐ Displays intense fear in a specific situation
(Specify) ______________________________

Eating disorders:

☐ Shows a decrease in appetite or weight loss since abuse such as a general lack of interest in food, anorexia, bulemia (Circle)
☐ Shows an increase in appetite (overeating, weight gain)

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Poor self-esteem:

☐ Is overly passive and unassertive
☐ Expresses an inordinate amount of guilt and self-blame
☐ Expresses an inordinate amount of shame regarding abuse
☐ Expresses discontent with body self image
☐ Assumes "victim" role (e.g., procrastination, overly dependent on others, fear of failure)

Substance abuse:

☐ Alcohol
☐ Street Drugs
☐ Prescribed medication
☐ Tobacco
☐ Other (specify) ____________________

Dissociative episodes or identity disorder:

☐ Tendency to withdraw into fantasy; appears disoriented, confused
☐ Inability to focus/sustain attention for reasonable period since abuse
☐ Intense ego state changes
☐ Intense ego state changes with some memory loss or co-consciousness
☐ Multiple personality disorder (separate & distinct parts of self each of which can be dominant to the exclusion of others)
☐ Repressed memories from childhood
☐ Unwillling or unable to discuss personal feelings
☐ Flat or inappropriate affect
☐ Engages in self abuse (e.g., pulls hair or nails, scratches or cuts self)

Other developmental problems:

☐ Shows regressive behavior following abuse such as thumbsucking, enuresis, encopresis, baby talk, clingy behavior, rocking, head banging, other (specify) ____________________ (Circle any or all that apply)
☐ Displays attention seeking/needy behaviors such as lying, exaggerating, stealing, interrupting, compliancy, defiancy, malingering, dawdling (Circle any or all that apply)
☐ Makes unusual comments about home or family life

G. Medical or Somatic Complaints

☐ Complains of pain during urination
☐ Has vaginal/penile discharge, inflammation, swelling, or bladder infections
☐ Has bruises, scratches, bites, or "passion" marks
☐ Has injury to lips or genital area (e.g., blood stains on underwear, rash arounnd lips)
☐ Has pain in anal, genital, gastrointestinal or urinary area
☐ Complains of nervous disorders: headaches, stomach aches, skin irritations (Circle or specify other) ____________________
☐ Acts inappropriately during a medical exam
☐ Pregnancy inappropriate for age or partner
☐ Developed a sexually transmitted disease/yeast infection following abuse
☐ Appears accident/illness prone
☐ Current prescriptive medication (specify) ____________________

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FAMILY GENOGRAM

□ = Male ○= Female

Comments

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APPENDIX B

Consent to Share Data Form

(Victoria Child Sexual Abuse Society and the Sexual Abuse and Disabilities Project at the University of Alberta)

University of Alberta
Edmonton

Canada T6G 2G5

Developmental Disabilities Centre
Abuse & Disability Project

6-102D Education North, Telephone (403) 492-3755
Fax (403) 492-1318
Project Director, Dick Sobsey

SAIR 305

29 July 1993

Rosemary Moskal
University of Alberta

Dear Rosemary:

I am writing this letter to formalize my request for data sharing. Our project studies the abuse of children and adults with disabilities. We have completed analysis from substantial numbers of cases of sexual abuse involving children with disabilities but have not used a control group of sexually abused children without disabilities. A controlled comparison of data from both groups is an important next step in our work. The data that you will be collecting from the Victoria Child Sexual Abuse Society could make an extremely valuable contribution to our work because it would allow us to analyse both similarities and differences between survivors of abuse with disabilities and those without disabilities.

In return for access to the data, our project will: (1) share all our findings with you and the Victoria Child Sexual Abuse Society; (2) offer you the opportunity to collaborate on publication of material arising from this data; (3) provide some assistance with the coding and analysis of the data that you collect (either as payment or by providing staff).

Our project has been reviewed by the University of Alberta Faculty of Education Ethics Review Committee and received approval for this work. The University of Alberta Abuse and Disability Project has an established reputation as a world leader in understanding and preventing abuse. We would be happy to provide any additional information that you require upon request.

Please let us know if this arrangement is satisfactory to you and the Victoria Child Sexual Abuse Society because if we cannot use this data we need to make arrangements to collect similar data from another source. Thank you for considering this proposal.

Sincerely,

Dick Sobsey
Principal Investigator

Victoria Child Sexual Abuse Society

101-3025 Shakespeare Street, Victoria, B.C. Canada V8R 4H6 Telephone: (604) 370-2111 Fax: (604) 370-2434

July 12, 1993

Dick Sobsey
Principal Investigator
Developmental Disabilities Centre
Abuse & Disability Project
6-102D Education North
University of Alberta
Edmonton, Alberta
T6G 2G5

Dear Mr. Sobsey;

I am pleased to respond to your letter addressed to Rosemary Moskal regarding sharing data for research purposes. The Victoria Child Sexual Abuse Society would be happy to share its data with your research team, provided the confidentiality of our clients is respected and the source of the data is acknowledged in any printed material resulting from the use of the data.

It is very generous of you to offer to share your findings with us and we appreciate that. I am sure Rosemary will also appreciate your help with her research efforts.

Yours very Truly,

Carol Ann Probert
Executive Director

✓ c.c. Rosemary Moskal

APPENDIX C

The Victoria Child Sexual Abuse Society Consent Form

SAIR 308

Victoria Child Sexual Abuse Society

101-3025 Shakespeare Street, Victoria, B.C. Canada V8R 4H6 Telephone: (604) 370-2111 Fax: (604) 370-2434

Application for Service

Please check off the services that you are requesting or you would like more information about:

1)_____Child and/or family assessment and counselling.

2)_____Information and support throughout your involvement with the criminal justice system.

3)_____Safety skills training for child.

4)Education and support groups
 _______Mom's group
 _______Parent's group
 _______Children's group
 _______Teen's Group

I am requesting the above services provided by the Victoria Child Sexual Abuse Society (VCSAS) in dealing with difficulties experienced by myself, child and/or family related to child sexual abuse.

I understand my involvement with the VCSAS is voluntary and confidential. Counsellors will be assigned as available and necessary to provide the services I have requested. I understand that confidential services means that the release of any information regarding my involvement with VCSAS may only occur with my written and signed consent. I have been informed that the exceptions to the confidential policy are:

a) unreported cases of suspected child abuse or neglect. VCSAS staff are obligated to inform appropriate persons in the Ministry of Social Services and Housing.
b) when a client indicates that he/she is in danger to himself/herself or others, VCSAS staff are obligated to inform the proper authorities.
c) upon subpoena to testify in court at the direction of a judge.

I also understand that information from my file may be used anonymously by VCSAS for the purposes of research into the prevention and intervention of child sexual abuse.

Re: Missed appointments:
If an appointment is missed without at least 24 hours notice, you may be charged $20.00.

______________________ ______________________
Signature **Date**

APPENDIX D

Computer Names for Variables in SAIR
(Phase Three in the Development of SAIR)

COMPUTER INPUT USING SPSSx (1988) AT CRAME
(University of Alberta)

VARIABLES FOR RECORD #1

Variable Column #	Variable (Computer Name)	Variable (Record Form Name)
FILE INFORMATION		
1 - 4	ID	File Information ID
5 - 6	RECORD 1	Record #
7	REFER	Referral source
8	RESID	Region of residence at time ... of referral for treatment
9	ABUSE	... at time of abuse
VICTIM INFORMATION		
10	GENDER	Male or Female
11 - 12	OFFENDER	Number of offenders
13 - 14	BEGAN	Age when abuse began
15 - 16	TERMIN	Age when abuse terminated
17 - 18	COUNSEL	Age when client in counselling
19 - 20	REASON	Reason abuse terminated
21 - 22	DISCLOSE	Disclosure situation
23 - 24	ETHNIC	Ethnic background of client
25	MENTAL	Mental disability
26	PHYSICAL	Physical disability
27	HEARING	Hearing disability
28	VISUAL	Visual disability
29	MOBILITY	Problem with mobility
30	NEUROL	Neurological impairment
31	DEVTAL	Developmentally delayed (IQ below 69)
32	AUTISM	Autistic
33	BORDER	Borderline/Low Average IQ (IQ 70 - 89)
34	LD	Learning disabled
35	ADD-ADHD	Attention deficit/with hyperactivity disorder
36	FAS-FAE	Fetal alcohol syndrome/effect
37	PSYCHL	Psychological/emotional problem(s)
38	OTHER	Type of problem not otherwise specified
39	PROGRAM	B.C. Gov't funded program for SA victims: (mentally and/or physically disabled)

VARIABLES FOR RECORD #1 cont'd

Column #	(Computer Name)	(Record Form Name)
FAMILY DEMOGRAPHICS		
		(In relation to client/victim)
40 - 41	BROTHER	Number of brothers
42 - 43	SISTERS	Number of sisters
44	BIRTHORD	Birth order
45	MHALF	Number of half brothers
46	MSTEP	Number of stepbrothers
47	MFOSTER	Number of foster brothers
48	FHALF	Number of half sisters
49	FSTEP	Number of stepsisters
50	FFOSTER	Number of foster sisters
51	BIOLSTAT	Biological parents' marital status at time of abuse
52	SAMEMATE	Mother has same or different mate now (at time victim is in counselling)
53	MOMSTAT	Mother's marital status now
54	HISTORY	Mother had a history of several mates
55	SRA	Suspected involved in satanic/ritual abuse
56	OFFENMD	Offender had a mental/physical disability

VARIABLES FOR RECORD #2

Variable Column #	Variable (Computer Name)	Variable (Record Form Name)
FAMILY ABUSE HISTORY		
		(as related to victim)
1 - 4	ID2	File Information ID
5 - 6	RECORD2	Record #2
Relationship Information of Victim to:		
7 - 8	OFFEND1	Offender #1 (1st account in family history)
9 - 10	VICTIM1	Victim #1
11	SA1	Abuse in #1 situation was sexual in nature
12	PA1	Abuse in #1 situation was physical violence
13	EA1	Abuse in situation #1 was emotional/verbal
14	NA1	Abuse in situation #1: abandonment/neglect
15	ALCOH1	1st account of alcohol dependent individual
16	DRUGS1	1st account of individual with drug abuse
17 - 18	OFFEND2	Offender #2 (2nd account in family history)
19 - 10	VICTIM2	Victim #2
21	SA2	Abuse in #2 situation was sexual in nature
22	PA2	Abuse in #2 situation was physical violence
23	EA2	Abuse in situation #2 was emotional/verbal
24	NA2	Abuse in situation #2: abandonment/neglect
25	ALCOH2	2nd account of alcohol dependent individual
26	DRUGS2	2nd account of individual with drug abuse
27 - 28	OFFEND3	Offender #3 (3rd account in family history)
29 - 30	VICTIM3	Victim #3
31	SA3	Abuse in #3 situation was sexual in nature
32	PA3	Abuse in #3 situation was physical violence
33	EA3	Abuse in situation #3 was emotional/verbal
34	NA3	Abuse in situation #3: abandonment/neglect
35	ALCOH3	3rd account of alcohol dependent individual
36	DRUGS3	3rd account of an individual with drug abuse

VARIABLES FOR RECORD #2 cont'd

Column #	(Computer Name)	(Record Form Name)
37 - 38	OFFEND4	Offender #4 (4th account in family history)
39 - 40	VICTIM4	Victim #4
41	SA4	Abuse in #4 situation was sexual in nature
42	PA4	Abuse in #4 situation was physical violence
43	EA4	Abuse in situation #4 was emotional/verbal
44	NA4	Abuse in situation #4: abandonment/neglect
45	ALCOH4	4th account of alcohol dependent individual
46	DRUGS4	4th account of an individual with drug abuse
47 - 48	OFFEND5	Offender #5 (5th account in family history)
49 - 50	VICTIM5	Victim #5
51	SA5	Abuse in #5 situation was sexual in nature
52	PA5	Abuse in #5 situation was physical violence
53	EA5	Abuse in situation #5 was emotional/verbal
54	NA5	Abuse in situation #5: abandonment/neglect
55	ALCOH5	5th account of alcohol dependent individual
56	DRUGS5	5th account of an individual with drug abuse
57 - 58	OFFEND6	Offender #6 (6th account in family history)
59 - 60	VICTIM6	Victim #6
61	SA6	Abuse in #6 situation was sexual in nature
62	PA6	Abuse in #6 situation was physical violence
63	EA6	Abuse in situation #6 was emotional/verbal
64	NA6	Abuse in situation #6: abandonment/neglect
65	ALCOH6	6th account of alcohol dependent individual
66	DRUGS6	6th account of an individual with drug abuse
67 - 68	OFFEND7	Offender #7 (7th account in family history)
69 - 70	VICTIM7	Victim #7
71	SA7	Abuse in #7 situation was sexual in nature
72	PA7	Abuse in #7 situation was physical violence
73	EA7	Abuse in situation #7 was emotional/verbal
74	NA7	Abuse in situation #7: abandonment/neglect
75	ALCOH7	7th account of alcohol dependent individual
76	DRUGS7	7th account of an individual with drug abuse

VARIABLES FOR RECORD #3

Variable Column #	Variable (Computer Name)	Variable (Record Form Name)
FAMILY ABUSE HISTORY		
		(as related to victim)
1 - 4	ID3	File Information ID
5 - 6	RECORD3	Record #3
Relationship Information of Victim to:		
7 - 8	OFFEND1B	Offender #8 (8th account in family history)
9 - 10	VICTIM1B	Victim #8
11	SA1B	Abuse in #8 situation was sexual in nature
12	PA1B	Abuse in #8 situation was physical violence
13	EA1B	Abuse in situation #8 was emotional/verbal
14	NA1B	Abuse in situation #8: abandonment/neglect
15	ALCOH1B	8th account of alcohol dependent individual
16	DRUGS1B	8th account of an individual with drug abuse
17 - 18	OFFEND2B	Offender #9 (9th account in family history)
19 - 10	VICTIM2B	Victim #9
21	SA2B	Abuse in #9 situation was sexual in nature
22	PA2B	Abuse in #9 situation was physical violence
23	EA2B	Abuse in situation #9 was emotional/verbal
24	NA2B	Abuse in situation #9: abandonment/neglect
25	ALCOH2B	9th account of alcohol dependent individual
26	DRUGS2B	9th account of an individual with drug abuse
27 - 28	OFFEND3B	Offender #10 (10th account in family history)
29 - 30	VICTIM3B	Victim #10
31	SA3B	Abuse in #10 situation was sexual in nature
32	PA3B	Abuse in #10 situation was physical violence
33	EA3B	Abuse in situation #10 was emotional/verbal
34	NA3B	Abuse in situation #10: abandonment/neglect
35	ALCOH3B	10th account of alcohol dependent individual
36	DRUGS3B	10th account of an individual with drug abuse

VARIABLES FOR RECORD #3 cont'd

Column #	(Computer Name)	(Record Form Name)
37 - 38	OFFEND4B	Offender #11 (11th account in family history)
39 - 40	VICTIM4B	Victim #11
41	SA4B	Abuse in #11 situation was sexual in nature
42	PA4B	Abuse in #11 situation was physical violence
43	EA4B	Abuse in situation #11 was emotional/verbal
44	NA4B	Abuse in situation #11: abandonment/neglect
45	ALCOH4B	11th account of alcohol dependent individual
46	DRUGS4B	11th account of an individual with drug abuse
47 - 48	OFFEND5B	Offender #12 (12th account in family history)
49 - 50	VICTIM5B	Victim #12
51	SA5B	Abuse in #12 situation was sexual in nature
52	PA5B	Abuse in #12 situation was physical violence
53	EA5B	Abuse in situation #12 was emotional/verbal
54	NA5B	Abuse in situation #12: abandonment/neglect
55	ALCOH5B	12th account of alcohol dependent individual
56	DRUGS5B	12th account of an individual with drug abuse
57 - 58	OFFEND6B	Offender #13 (13th account in family history)
59 - 60	VICTIM6B	Victim #13
61	SA6B	Abuse in #13 situation was sexual in nature
62	PA6B	Abuse in #13 situation was physical violence
63	EA6B	Abuse in situation #13 was emotional/verbal
64	NA6B	Abuse in situation #13: abandonment/neglect
65	ALCOH6B	13th account of alcohol dependent individual
66	DRUGS6B	13th account of an individual with drug abuse
67 - 68	OFFEND7B	Offender #14 (14th account in family history)
69 - 70	VICTIM7B	Victim #14
71	SA7B	Abuse in #14 situation was sexual in nature
72	PA7B	Abuse in #14 situation was physical violence
73	EA7B	Abuse in situation #14 was emotional/verbal
74	NA7B	Abuse in situation #14: abandonment/neglect
75	ALCOH7B	14th account of alcohol dependent individual
76	DRUGS7B	14th account of an individual with drug abuse

VARIABLES FOR RECORD #4

Variable Column #	Variable (Computer Name)	Variable (Record Form Name)

OFFENDER AND ABUSE INCIDENTS INFORMATION

Note: This record was run through 9 times in order to accommodate the data from variables in columns #26-27 (Relationship of investigation for each offender).

		(as related to offender)
1 - 4	ID4	File Information ID
5 - 6	RECORD4	Record #4 (1st recorded offender)
7 - 8	OFFENUM	Offender # (offender #1 is being recorded from total possible # of offenders)
9 - 10	OFFENPOS	Total # of offenders reported by victim
11	GENDER4	Male or Female
12 - 13	AGESTART	Age of offender #1 at time offence began
14 - 15	AGETERM	Age of offender #1 when offence terminated
16 - 18	MONTHS	Duration of sexual abuse in months
19 - 20	AGEDIFF	Age difference between offender #1 & victim
21	FREQ4	Frequency of offence occurences(s)
22	ED-OCC	Offender's educ'n/occupation during abuse
23	MARITAL	Marital status of offender #1 during abuse
24	ADDICT	Offender #1 addictions
25	ABUSE4	Other types of abuse by offender #1 to victim
26 - 27	RELATE4 **(NWRELT4)**	Relationship of offender #1 to victim
28	IN-EXTRA	Classification of abuse for 1st relationship
29	TYPE	Type of sexual abuse for offender #1 (i.e., degree of intrusiveness)
30	PATTERN	Was there a pattern to the offences?
31 - 32	TIME	Typical pattern in time abuse occurred
33 - 34	PLACE	Typical p[attern in place abuse occurred
35	OTHER4	Other pattern not specified by offender #1
36	ALLEGE	Who alleged sexual abuse had occurred?
37	REPORT	Was the abuse by offender #1 reported to the police?
38	CHARGE	Were charges laid against offender #1?

VARIABLES FOR RECORD #4 cont'd

Column #	(Computer Name)	(Record Form Name)
		If charges were laid against offender #1:
39	PRISON	Sentenced to a prison term
40	PROBN	Sentenced to receive a probation period
41	COUNSEL1	Sentenced to receive mandatory/forensic counselling
42	COMMUNIT	Sentenced to receive community service hours
43	ISOLATE	Sentenced to receive restraining order from victim
44	ACQUITED	Charges against offender #1 were dropped
45 - 46	REASON4 (NWOUTC1)	Reason for outcome of investigation
47	CIC	Criminal Injuries Compensation paid for victim to receive counselling

VARIABLES FOR RECORD #4
(2nd run out of 9 runs)

Variable Column #	Variable (Computer Name)	Variable (Record Form Name)
OFFENDER AND ABUSE INCIDENTS INFORMATION		(as related to offender)
1 - 4	ID4B	File Information ID
5 - 6	RECORD4B	Record #4 (2nd recorded offender)
7 - 8	OFFENM2	Offender # (offender #2 is being recorded from total possible # of offenders)
9 - 10	OFFENPO2	Total # of offenders reported by victim
11	GENDER4B	Male or Female
12 - 13	AGESTART2	Age of offender #2 at time offence began
14 - 15	AGETERM2	Age of offender #2 when offence terminated
16 - 18	MONTHS2	Duration of sexual abuse in months
19 - 20	AGEDIFF2	Age difference between offender #2 & victim
21	FREQ4B	Frequency of offence occurences(s)
22	ED-OCC2	Offender's educ'n/occupation during abuse
23	MARITAL2	Marital status of offender #2 during abuse
24	ADDICT2	Offender #2 addictions
25	ABUSE4B	Other types of abuse by offender #2 to victim
26 - 27	RELATE4B **(NWRELT4B)**	Relationship of offender #2 to victim
28	IN-EXTRA2	Classification of abuse for 2nd relationship
29	TYPE2	Type of sexual abuse for offender #2 (i.e., degree of intrusiveness)
30	PATTERN2	Was there a pattern to the offences?
31 - 32	TIME2	Typical pattern in time abuse occurred
33 - 34	PLACE2	Typical p[attern in place abuse occurred
35	OTHER4B	Other pattern not specified by offender #2
36	ALLEGE2	Who alleged sexual abuse had occurred?
37	REPORT2	Was the abuse by offender #2 reported to the police?
38	CHARGE2	Were charges laid against offender #2?
If charges were laid against offender #2:		
39	PRISON2	Sentenced to a prison term
40	PROBN2	Sentenced to receive a probation period
41	COUNSEL2	Sentenced to receive mandatory/forensic counselling
42	COMMUNI2	Sentenced to receive community service hours
43	ISOLATE2	Sentenced to receive restraining order from victim
44	ACQUITE2	Charges against offender #2 were dropped
45 - 46	REASON4B **(NWOUTC1B)**	Reason for outcome of investigation
47	CIC2	Criminal Injuries Compensation paid for victim to receive counselling

VARIABLES FOR RECORD #4
(3rd to 9th run)

OFFENDER AND ABUSE INCIDENTS INFORMATION

Variable Column #	Variable (Computer Name)	Variable (Record Form Name)
		(as related to offender)
1 - 4	ID4C-I	File Information ID (same ID # for all 9 runs)
5 - 6	RECORD4C	Record #4 (3rd recorded offender)
	RECORD4D	Record #4 (4th recorded offender)
	RECORD4E	Record #4 (5th recorded offender)
	RECORD4F	Record #4 (6th recorded offender)
	RECORD4G	Record #4 (7th recorded offender)
	RECORD4H	Record #4 (8th recorded offender)
	RECORD4I	Record #4 (9th recorded offender)
7 - 8	OFFENM3 (OFFENM4/5/6/7/8/9)	Offender # (offender #3 is being recorded from total possible # of offenders)
9 - 10	OFFENPO3 (OFFENPO4/5/6/7/8/9)	Total # of offenders reported by victim
11	GENDER4C (GENDER4D/E/F/G/H/I)	Male or Female
12 - 13	AGESTART3 (AGESTART4/5/6/7/8/9)	Age of offender #3 at time offence began
14 - 15	AGETERM3 (AGETERM4/5/6/7/8/9)	Age of offender #3 when offence terminated
16 - 18	MONTHS3 (MONTHS4/5/6/7/8/9)	Duration of sexual abuse in months
19 - 20	AGEDIFF3 (AGEDIFF4/5/6/7/8/9)	Age difference between offender #3 & victim
21	FREQ4C (FREQ4D/E/F/G/H/I)	Frequency of offence occurences(s)
22	ED-OCC3 (ED-OCC4/5/6/7/8/9)	Offender's educ'n/occupation during abuse

VARIABLES FOR RECORD #4
(3rd to 9th run cont'd)

Offender characteristics cont'd:

Column #	(Computer Name)	(Record Form Name)
23	MARITAL3 (MARITAL4/5/6/7/8/9)	Marital status of offender #3 during abuse
24	ADDICT3 (ADDICT4/5/6/7/8/9)	Offender #3 addictions
25	ABUSE4C (ABUSE4D/E/F/G/H/I)	Other types of abuse by offender #3 to victim
26 - 27	RELATE4C **(NWRELT4C)** **(NWRELT4D/E/F/G/H/I)**	Relationship of offender #3 to victim
28	IN-EXTRA3 (IN-EXTRA4/5/6/7/8/9)	Classification of abuse for 3rd relationship
29	TYPE3 (TYPE4/5/6/7/8/9)	Type of sexual abuse for offender #3 (i.e., degree of intrusiveness)
30	PATTERN3 (PATTERN4/5/6/7/8/9)	Was there a pattern to the offences?
31 - 32	TIME3 (TIME4/5/6/7/8/9)	Typical pattern in time abuse occurred
33 - 34	PLACE3 (PLACE4/5/6/7/8/9)	Typical pattern in place abuse occurred
35	OTHER4C (OTHER4D/E/F/G/H/I)	Other pattern not specified by offender #3
36	ALLEGED3 (ALLEGED4/5/6/7/8/9)	Who alleged sexual abuse had occurred?
37	REPORT3 (REPORT4/5/6/7/8/9)	Was the abuse by offender #3 reported to the police?
38	CHARGE3 (CHARGE4/5/6/7/8/9)	Were charges laid against offender #3?

VARIABLES FOR RECORD #4
(3rd to 9th run cont'd)

Column #	(Computer Name)	(Record Form Name)
		If charges were laid against offender #3:
39	PRISON3 (PRISON4/5/6/7/8/9)	Sentenced to a prison term
40	PROBN3 (PROBN4/5/6/7/8/9)	Sentenced to receive a probation period
41	COUNSEL3 (COUNSEL4/5/6/7/8/9)	Sentenced to receive mandatory/forensic counselling
42	COMMUNI3 (COMMUNI4/5/6/7/8/9)	Sentenced to receive community service hours
43	ISOLATE3 (ISOLATE4/5/6/7/8/9)	Sentenced to receive restraining order from victim
44	ACQUITE3 (AQUITE4/5/6/7/8/9)	Charges against offender #3 were dropped
45 - 46	REASON4C **(NWOUTC1C)** **(NWOUTC1D/E/F/G/H/I)**	Reason for outcome of investigation
47	CIC3 (CIC4/5/6/7/8/9)	Criminal Injuries Compensation paid for victim to receive counselling

VARIABLES FOR RECORD #5
Sexual Abuse Sequelae During Counselling

Variable Column #	Variable (Computer Name)	Variable (Record Form Name)
1 - 4	ID5	File Information ID
5 - 6	RECORD5	Record #5

A. SCHOOL/WORK/COUNSELLING ACTIVITIES

7	A-INSIST	Insists on attending school/work/counselling even if ill
8	A-AVOIDS	Avoids school/work/counselling
9	A-DECLIN	Shows sudden decline in school/work/counselling performance
10	A-CONCEN	Has difficulty concentrating or staying on task
11	A-REFUSE	Refuses to participate in some school/work/counselling activities
12	A-BEHAV	Extremely demanding or withdrawn at school/work/counselling related activities
13	A-DEMAND	Extremely demanding at activities cited above
14	A-WITHDR	Extremely withdrawn at activities cited above
15	A-GYM	Unwillingness to undress for gym or participate in physical education activities
16	A-ART	Sexualized or bizarre art work or stories which depict themes of sexually abusive behavior (e.g., body proportions skewed, death wishes)

B. PERSONAL RELATIONSHIPS

17	B-LED	Is easily led or influenced/tries hard to please others
18	B-ROLE	Role reversal/enmeshment with mother or father
19	B-BEHAV	Is very shy or withdrawn: Avoids peers/men/women
20	B-PEERS	Avoids peers
21	B-MEN	Avoids men
22	B-WOMEN	Avoids women
23	B-FRIEND	Has few friends
24	B-TRUST	Inability to establish trusting close personal relationships
25	B-AGGRES	Displays dominant/aggressive behavior toward others
26	B-ANGER	Shows inappropriate anger
27	B-PATTER	Repeats a pattern of engaging in abusive relationships

VARIABLES FOR RECORD #5 cont'd
Sexual Abuse Sequelae During Counselling

Column # (Computer Name) (Record Form Name)

C. SEXUALITY

28	C-GAMES	Initiates "sexual games" with adults and/or children
29	C-ADULTS	Initiates "sexual games" with adults
30	C-CHILDN	Initiates "sexual games" with children
31	C-BEHAV	Touches self/adults/children/animals excessively or inappropriately
32	C-SELF	Touches self excessively or inappropriately
33	C-ADULT	Touches an adult or adults excessively or inappropriately
34	C-CHILD	Touches a child/children excessively or inappropriately
35	C-ANIMAL	Touches an animal or animals inappropriately
36	C-MASTUR	Masturbates excessively for age level
37	C-CONFUS	Shows confusion regarding his/her sexual orientation
38	C-DYSFUN	Experiences sexual dysfunction (e.g., impotency, fear of sexual intimacy, dislikes sex)
39	C-REMARK	Verbalizes inappppropriate "sexual" remarks or comments
40	C-THINKS	Preoccupied with sexual thoughts or fantasies (e.g., pornography, doll's genitals during play)
41	C-SAFETY	Approaches strangers inappropriately/poor sense of personal safety
42	C-APPROV	Is approval seeking with adults or children
43	C-LITTLE	Presents as a "little adult"
44	C-DRESS	Dresses inappropriately (i.e., seductively or layering)
45	C-SEDUCT	Dresses seductively to expose body
46	C-LAYER	Dresses in layers to cover up body
47	C-AFFECT	Has difficulty distinguishing between affection and sexual encounters
48	C-ACTIVE	Is sexually promiscuous or has knowledge of sexual activity inappropriate to age level
49	C-INACTI	Has little or no age appropriate sexual knowledge

D. BEDTIME

50	D-AVOIDS	Avoids going to bed or refuses to sleep alone
51	D-CLOTHE	Insists on sleeping fully clothed
52	D-INSOMN	Sleep disorder (insomnia, hypersomnia, uses sedatives)
53	D-NOBED	Refuses to sleep in bed preferring chair, floor...)
54	D-WEAPON	Keeps a weapon such as a club or knife close by bed
55	D-NIGHTM	Has nightmares or recurring dreams

VARIABLES FOR RECORD #5 cont'd
Sexual Abuse Sequelae During Counselling

Column #	(Computer Name)	(Record Form Name)

E. HYGIENE

56	E-MODEST	Exhibits excessive modesty surrounding bathroom or bedroom functions
57	E-IMMOD	Is immodest, uninhibited in the bathroom or other areas of home or in a social situation
58	E-INTRUD	Tries to "spy" on or intrudes on others in areas of privacy
59	E-UPSET	Becomes agitated during bathroom or bedroom routine(s)
60	E-BEHAV	Appears unkempt/dirty or cleans/grooms self excessively
61	E-DIRTY	Appears unkempt or dirty on a regular basis
62	E-GROOMS	Appears to be overly concerned with personal cleanliness/appearance
63	E-MENSES	Excessive problems with menses (e.g., obsessive fear, fascination, poor hygiene)

VARIABLES FOR RECORD #6
Sexual Abuse Sequelae During Counselling

Variable Column #	Variable (Computer Name)	Variable (Record Form Name)
1 - 4	ID6	File Information ID
5 - 6	RECORD6	Record #6

F. BEHAVIORAL/EMOTIONAL SYMPTOMS

7	F-BEHAV	Appears depressed, threatens and/or attempts suicide
8	F-DEPRES	Appears depressed on a regular basis
9	F-THREAT	Makes threats about hurting self or taking own life
10	F-ATTEM	Attempts suicide or has in past following abuse
11	F-MAD	Expresses homicidal ideation/intense anger towards someone
12	F-IDEA	Expresses homicidal ideation/intense anger towards (explain ____________________)
13	F-ANGER	Expresses intense anger towards (explain ____________________)
14	F-CHANGE	Shows a sudden behavior change (explain ____________________)
15	F-RUNS	Runs away or threatens to run away
16	F-NERVES	Appears unusually nervous or anxious
17	F-PHOBIC	Shows phobic or other avoidance behavior (e.g., panic attacks, flashbacks)
18	F-PANIC	Experiences panic attacks
19	F-FLASH	Experiences flashbacks of abuse
20	F-FEAR	Displays extreme fear of a specific person, place, situation
21	F-PLACE	Displays intense fear of a specific place (explain ____________________)
22	F-PERSON	Displays intense fear of a specific person (explain ____________________)
23	F-SITN	Displays intense fear in a specific situation (explain ____________________)
24	F-CHOKE	Has memories/fears/bouts of choking, suffocating, stuttering
25	F-LOSE	Expresses fear about losing control and becoming abusive to self or others
26	F-REGRES	Shows regressive behavior (e.g., thumbsucking, enuresis, encopresis, baby talk, clingy behavior)
27	F-THUMB	Regresses to thumbsucking following abuse
28	F-ENURES	Regresses to enuresis following abuse
29	F-ENCOPR	Regresses to encopresis following abuse
30	F-TALK	Regresses to baby talk following abuse
31	F-CLINGY	Regresses to clingy behavior following abuse

VARIABLES FOR RECORD #6 cont'd
Sexual Abuse Sequelae During Counselling

Column # (Computer Name) (Record Form Name)

Behavioral/Emotional Symptoms cont'd

32	F-COMMEN	Makes unusual comments about home or family life
33	F-DOLLS	Is overly interested in genital areas of dolls during play
34	F-NEEDY	Displays attention seeking/needy behaviors (e.g., lying exaggerating, stealing, interrupting, malingering, dawdling)
35	F-EATING	Has a change in appetite: anorexic/bulemic or overeating
36	F-ANOREX	Shows a decrease in appetite (e.g., anorexia/bulemia)
37	F-OVERW	Shows an increase in appetite (overeating, weight gain)
38	F-ESTEEM	Has poor self-esteem (e.g., unassertive, guilt, shame, poor body image)
39	F-UNASSR	Is overly passive and unassertive
40	F-GUILT	Expresses an inordinate amount of guilt and self-blame
41	F-SHAME	Expresses an inordinate amount of shame regarding abuse
42	F-BODY	Expresses discontent with body self image
43	F-VICTIM	Assumes "victim" role (e.g., procrastination, overly dependent on others, fear of failure)
44	F-SUBSTA	Use and/or abuse of substances (alcohol, drugs, tobacco)
45	F-USE	Use of substances (alcohol, drugs, tobacco)
46	F-ABUSE	Abuse of substances (alcohol, drugs, tobacco)
47	F-ALCOH	Use/abuse of alcohol
48	F-DRUGS	Use/abuse of drugs
49	F-CIGS	Use/abuse of tobacco
50	F-DID	Experiences dissociative episodes
51	F-FANTAS	Tendency to withdraw into fantasy
52	F-FOCUS	Inability to focus/sustain attention for reasonable period
53	F-EGO	Intense ego state changes
54	F-EGOLOS	Intense ego state changes with some memory loss
55	F-MPD	Multiple personality disorder
56	F-REPRES	Repressed memories from childhood
57	F-DETACH	Detachment of cognitive functioning from emotional functioning (e.g., inability to discuss feelings, flat or inappropriate affect)
58	F-DISCUS	Unwillling or unable to discuss personal feelings
59	F-NOAFFE	Flat or inappropriate affect
60	F-SELFAB	Engages in self abuse (e.g., pulls hair or nails, head banging, scratches or cuts self)

VARIABLES FOR RECORD #6 cont'd
Sexual Abuse Sequelae During Counselling

Column # (Computer Name) (Record Form Name)

G. MEDICAL/SOMATIC COMPLAINTS

61	G-URINE	Complains of pain during urination
62	G-DISCHA	Has vaginal/penile discharge, inflammation, swelling, or bladder infections
63	G-BRUISE	Has bruises, scratches, bites, or "passion" marks
64	G-INJURY	Has injury to lips or genital area (e.g., blood stains on underwear, rash arounnd lips)
65	G-PAIN	Has pain in anal, genital, gastrointestinal or urinary area
66	G-BEHAV	Complains of nervous disorders (e.g., headaches, stomach aches, skin irritations)
67	G-HEADAC	Complains of headaches regularly
68	G-STOMAC	Complains of stomach aches regularly
69	G-SKIN	Complains of skin irritations regularly
70	G-EXAM	Acts inappropriately during a meducal exam
71	G-PREGNA	Pregnancy inappropriate for age or partner
72	G-STD	Developed a sexually transmitted disease/yeast infection following abuse
73	G-ACCID	Appears accident/illness prone

APPENDIX E

Continuing Research Using SAIR Data: Hypotheses Generated by the Sexual Abuse and Disabilities Project, University of Alberta

Continuing Research Using SAIR Data

(Hypotheses Generated by Professor R. Sobsey, Director of the SA and Disabilities Project, University of Alberta)

Categories of Disability Compared	
350 without Disabililites	102 with Disabilities
350 without Disabililites	51 in Disabilities Program

1. Do referral sources differ by category?
   Hypothesis: *Fewer self referrals and more agency referrals among disabled.*

2. Does the overall proportion of boys and girls differ by category?
Hypothesis: *More boys among the disabled.*

3. Does the proportion of boys and girls differ by category controlled for age groupings?
Hypothesis: *More boys at later age among disabled in older groups.*

4. Is the number of offenders different for categories?
Hypothesis: *More offenders in disabled group.*

5. Is the time between initiation and termination of abuse different across categories?
Hypothesis: *Longer time for the disabled group.*

6. Does the termination date differ across groups?
Hypothesis: *Later termination for disabled group.*

7. Does the reason for termination differ across groups?
Hypothesis: *None.*

8. Does the disclosure situation differ across groups?
Hypothesis: *None.*

9. Does the ethnic background differ across groups?
Hypothesis: *Fewer minorities in disabled group.*

10. Do categories of family (biological) relationship status differ across categories?
Hypothesis: *None.*

11. Does family history of abuse differ across categories?
Hypothesis: *Less family history of abuse among disabled group.*

12. Does drug and alcohol abuse differ across groups?
Hypothesis: *More frequent among disabled group.*

13. Does the frequency of other forms of abuse differ across across groups?
Hypothesis: *More frequent among disabled group.*

14. Does the gender of offenders (M/F/Both) differ across groups?
Hypothesis: *More both among disabled group.*

15. Does the age of offenders differ by group?
Hypothesis: *Older offenders among disabled group.*

16. Does the frequency of abuse differ across groups?
Hypothesis: *More ≥ 10 among disabled group.*

17. Does occupations differ across categories?
Hypothesis: *More human service professionas among disabled.*

18. Does the frequency of drug and alcohol abuse differ across groups?
Hypothesis: *More frequent among disabled group.*

19. Does offender relationship status differ across groups?
Hypothesis: *None.*

20. Does other abuse by offenders differ across groups?
Hypothesis: *More other abuse among disabled.*

21. Does the distribution of intrafamilial and extrafamilial abuse differ across categories?
Hypothesis: *More extrafamilial abuse among the disabled.*

22. Does the number of "position of trust" offenders differ across groups?
Hypothesis: *More frequent among the disabled group.*

23. Does the distribution categories of intrusiveness of abuse differ across groups?
Hypothesis: *More frequent intrusive and very intrusive abuse among disabled group.*

24. Does the time of abuse differ across groups?
Hypothesis: *None.*

25. Does the place of abuse differ across groups?
Hypothhesis: *None.*

26. Does the frequency of reports to police differ across groups?
Hypothesis: *Fewer reports to police among disabled.*

27. Does the frequency of charges differ across categories?
Hypothesis: *Fewer charges among disabled victims.*

28. Did sentence differ across groups?
Hypothesis: *Lighter sentences among the disabled group.*

29. Did the frequency of reports of major categories of sequelae differ across groups within each major cluster of sequelae?
Hypothesis: *None.*

30-36. Did the frequency of reports of minor categories of sequelae differ across groups within each major cluster of sequelae?
Hypothesis: *None.*

37-73. Repeat initial comparisions comparing male and female victims with and without disablilties.